IN THE
SUPREME COURT OF THE UNITED STATES

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, AND HEALTH ALLIANCE MEDICAL PLANS, INC.,
Petitioners,

v.

CYNTHIA HERDRICH,
Respondent.

On Petition for Writ of Certiorari to the
United States Court of Appeals
for the Seventh Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Whether a health maintenance organization ("HMO") and its physicians breach a fiduciary duty under section 404(a)(1) of the Employee Retirement Income Security Act of 1974, 29 U.S.C. §1404(a)(1), by implementing a managed care program in which the physicians receive financial incentives to provide medical care to the HMO's enrollees in a cost-effective manner.

PARTIES TO THE PROCEEDING

All parties to the proceeding are listed in the caption of the case. There are no additional parent companies or nonwholly owned subsidiaries of the parties. See Sup. Ct. R. 29.6.

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Petitioners, Lori Pegram, M.D., Carle Clinic Association, and Health Alliance Medical Plans, Inc., respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Seventh Circuit in this case.

OPINIONS BELOW

The opinion of the court of appeals and the dissent thereto (App. 1a-47a) were entered on August 18, 1998, and are reported at 154 F.3d 362 (7th Cir. 1998). The order of the court of appeals denying the petition for rehearing and the suggestion for rehearing *en banc* was entered on March 8, 1999; that order and the dissent from the denial of rehearing *en banc* (App. 48a-58a) are reported at 170 F.3d 683 (7th Cir. 1998). The opinion of the United States District Court for the

Central District of Illinois, adopting a magistrate judge's recommendation that petitioners' motion to dismiss Count III of respondent's amended complaint (the count at issue here) should be granted (App. 59a-60a), is not reported. The recommendation of the magistrate judge (App. 61a-64a) is not reported. A previous opinion of the district court, granting petitioners' motion for summary judgment on two state-law counts in respondent's complaint, but also granting respondent leave to amend her complaint to state a claim under the Employee Retirement Income Security Act (App. 65a-80a), is not reported. The February 10, 1997 judgment of the district court reflecting the jury verdict in this case (App. 81a-82a) is not reported.

JURISDICTION

The court of appeals entered its judgment on August 18, 1998. Petitioners timely filed a petition for rehearing and suggestion for rehearing *en banc* on September 1, 1998. On March 8, 1999, the court of appeals issued its decision and order denying petitioners' petition for rehearing and suggestion for rehearing *en banc*. App. 48a-58a. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTE INVOLVED

The statute involved in this case is the Employee Retirement Income Security Act of 1974, section 3(21)(A), 29 U.S.C. § 1002(21)(A), which is set forth *infra*, at 19, and section 404(a)(1), 29 U.S.C. § 1104(a)(1), which provides:

> [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and --

> (A) for the exclusive purpose of:
>
> > (i) providing benefits to participants and their beneficiaries; and
> > (ii) defraying reasonable expenses of administering the plan;
>
> (B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

STATEMENT OF THE CASE

1. State Farm Insurance Company entered into a contract with petitioner, Health Alliance Medical Plans, Inc. ("HAMP") to provide medical and hospital services to State Farm's employees and their families. HAMP operates a health maintenance organization ("HMO") -- that is, a pre-paid health insurance plan which, for a fixed monthly payment per covered individual, provides health care benefits through the Carle Clinic Association ("Carle Clinic") and other participating providers. Carle Clinic is a professional medical corporation owned by its physician shareholders. In addition, Carle Clinic is the sole shareholder both of HAMP and a management entity known as the Carle Health Insurance Management Co., Inc. ("CHIMCO"). App. 4a n.3. Like other HMOs and managed care plans, the plan contains features designed to encourage cost containment, including requirements that participants and beneficiaries see Carle Clinic physicians or other participating

providers, obtain only medically-necessary treatment, and use only plan-approved facilities.[1]

Respondent Cynthia Herdrich's husband was employed by State Farm; and, accordingly, she was covered under petitioners' plan. In March 1992, Herdrich's appendix ruptured as the result of allegedly improper medical treatment she received from Dr. Lori Pegram, a Carle Clinic physician. As a result, on October 21, 1992, Herdrich filed a complaint against Pegram and Carle Clinic in the Circuit Court of McLean County, Illinois, alleging professional medical negligence. On February 18, 1994, Herdrich amended her complaint to add two state-law counts (Count III, alleging a violation of the Illinois Consumer Fraud Act, and Count IV, alleging a violation of a contractual duty of good faith and fair dealing) against petitioners.

Petitioners then removed the case to federal court, asserting that the two new counts were preempted by ERISA, and further sought summary judgment on the new claims. The district court agreed that ERISA preempted both claims. The court further granted petitioners summary judgment on Count IV. It determined that, even if Count IV were re-pled as an ERISA claim, petitioners would be entitled to summary judgment, because Herdrich was seeking monetary relief,

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[1] For example, the Group Subscription Certificate for CarleCare HMO, the HAMP plan under which Ms. Herdrich was covered, explains that the plan does not cover "[c]are by Physicians, other than CarleCare Physicians or Providers, or in hospitals not associated with CarleCare (except in a medical emergency or [when referred by the Primary Care Physicians])" and that X-ray and laboratory tests and services approved by the CarleCare Medical Policy Committee are covered only "when Medically Necessary, requested by the CarleCare Physician and obtained at an approved CarleCare facility." *See* Group Subscription Certificate (Exhibit A to Herdrich's Complaint). App. 103a, 118a.

including extra-contractual damages, which ERISA does not allow. But the court granted Herdrich "leave to submit an amended Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." App. 79a-80a.

On September 1, 1995, Herdrich filed her amended Count III. That count is the subject of the decision at issue here. In amended Count III, Herdrich alleged that petitioners breached their fiduciary duty to plan participants and beneficiaries by implementing cost-containment mechanisms that provided physicians with financial rewards based on the extent to which the plan successfully contained the costs of providing health care.[2]

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[2] Specifically, Herdrich alleged that:

> In breach of that [fiduciary] duty:
>
> a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;
>
> b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:
>
> i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:
> (1) minimize the use of diagnostic tests;
> (2) minimize the use of facilities not owned by Carle; and
> (3) minimize the use of emergency and

(continued...)

Petitioners filed a motion to dismiss amended Count III pursuant to Fed. R. Civ. P. 12(b)(6). The magistrate judge assigned, by agreement of the parties, to hear the case recommended that petitioners' motion be granted, although he also recommended that Herdrich receive one last opportunity to plead an ERISA claim. App. 64a. Herdrich objected to the magistrate judge's recommendation pursuant to Fed. R. Civ. P. 72. On April 15, 1996, however, the district court adopted the magistrate judge's recommendation of dismissal. Herdrich chose not to re-plead.

After discovery, the remaining state-law counts of Herdrich's complaint went to trial in early December 1996. The jury returned a verdict in Herdrich's favor on these state-law medical malpractice claims and awarded her $35,000 in compensatory damages. App. 81a.

2. Herdrich then appealed the district court's earlier dismissal of the ERISA claim in amended Count III of her

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[2] (...continued)

non-emergency consultation and/or referrals to noncontracted physicians.
ii. by administering disputed and non-routine health insurance claims and determining:
(1) which claims are covered under the Plan and to what extent;
(2) what the applicable standard of care is;
(3) whether a course of treatment is experimental;
(4) whether a course of treatment is reasonable and customary; and
(5) whether a medical condition is an emergency. [Complaint (quoted App. 4a n.3).]

complaint. The court of appeals reversed the judgment of dismissal.[3] It determined that the bare allegation that petitioners implemented cost-containment mechanisms that included potential rewards for physicians based on the plan's financial performance sufficed to state an ERISA claim for breach of fiduciary duty. Specifically, the court of appeals held that petitioners were acting as fiduciaries when they made the judgment to establish the cost-containment measures and the financial rewards. And, the court concluded, an allegation that petitioners created and implemented a system which might create divided loyalties in a physician sufficed to state an ERISA claim for breach of fiduciary duty:

> The Plan dictated that the very same HMO administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. [App. 18a (emphasis omitted).]

In reaching its conclusion, the court detailed its view that cost-containment mechanisms substantially erode the quality of American health care and should be eliminated. *Id.* at 24a-32a.

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[3] The court of appeals first determined that Herdrich had timely filed her notice of appeal. App. 9a. Petitioners do not seek review of that decision.

Finally, the court of appeals held that Herdrich had adequately pled damage to the plan as a result of the breach. *Id.* at 38a.

Judge Flaum dissented. He observed that the complaint simply "alleges that there is a conflict of interest built into the compensation structure of the health plan in question" and accepted "the Majority's conclusion that, taking the allegations of the complaint as true, 'an incentive existed for [petitioners] to limit treatment and, in turn, HMO costs so as to ensure larger bonuses.'" App. 38a-39a. But he disagreed with the Majority's holding "that the mere existence of this asserted conflict, without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." *Id.* at 39a. As Judge Flaum explained, "many sponsors and beneficiaries of managed care plans view financial incentives as a desirable way of conserving the plan's assets by encouraging physicians to use resources more efficiently." *Id.* at 43a. Thus, "merely alleging the existence of financial incentives to limit care cannot suffice to make out a claim of breach of fiduciary duty." *Id.*

Petitioners sought rehearing and filed a suggestion for rehearing *en banc*. The court of appeals denied the petition on March 8, 1999. App. 48a-49a. Judge Easterbrook, joined by Chief Judge Posner and Judges Flaum and Wood, dissented from denial of rehearing *en banc*. The dissenting opinion persuasively explains why the issues in this case are of national importance, why the court of appeals' decision will have widespread and damaging repercussions, and why the decision is wrong. *Id.* at 49a-58a. Rather than summarize that opinion here, petitioners incorporate its points in their demonstration that this case warrants certiorari.

REASONS FOR GRANTING THE PETITION

The court of appeals held that a health maintenance organization ("HMO") and its physicians act as fiduciaries under the Employee Retirement Income Security Act of 1974 ("ERISA") when they implement a managed care program in which physicians receive financial incentives to provide medical care to the HMO's members in a cost-effective manner. The court further held that the bare allegation that an HMO has adopted such cost-containment features (as numerous health plans have) states a claim for breach of fiduciary duty under ERISA. The court of appeals is wrong, and the consequences of that error are dangerous and disruptive to health care providers and the nation's overall system of health care delivery.

The court's essential holding is that ERISA health care plans "have a fiduciary duty not to adopt HMO[s] or other managed-care options," because cost-containment incentives create a conflict of interest for the health care provider. App. 54a (Easterbrook, J., dissenting from denial of rehearing *en banc*) (hereafter "Easterbrook, J., dissenting"). Accordingly, "[b]y stretching the definition of a 'fiduciary' under ERISA, [the court of appeals] has effectively foreclosed a popular option for the delivery of medical care and taken the decision out of private hands, to which ERISA committed it." *Id.* (Easterbrook, J., dissenting). This decision -- that health plans which include incentives to health care providers to contain costs are unlawful -- is of profound national importance. "Most medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option." *Id.* at 56a. (Easterbrook, J., dissenting). If the court of appeals' decision stands, then "the principal organizational forms through which medical care is delivered today are unlawful." *Id.* (Easterbrook, J., dissenting).

This consequence is contrary to the expressed will of Congress, which has expressly authorized managed health care, including HMOs. Indeed, Congress has specifically authorized HMOs to enter into contracts which financially reward their physicians for minimizing expensive treatment. See 42 U.S.C. § 300e; see also 42 U.S.C. § 1395w-25 (authorizing Medicare to contract with HMOs and other managed care organizations established by physicians). The social and economic consequences of the court of appeals' decision cannot be overstated: At a minimum, physicians and other health care providers who contract with employers to provide managed care plans now face a substantial risk that they will be sued in federal court for breach of fiduciary duty whenever a participant or beneficiary disapproves of cost-containment incentives established by the plan. Likewise, providers will face liability under ERISA whenever a participant or beneficiary questions a medical judgment that might have been affected by a cost-containment incentive. Equally to the point, the health care industry constitutes a significant sector of the United States economy, and it will be drastically affected if the current widespread use of cost-containment incentives is unlawful in ERISA plans.

It is particularly ironic that the court of appeals extended the scope of ERISA fiduciary liability in a case involving a *physician-owned* managed care plan. Physician-controlled health plans have been advocated by some as an antidote to the perceived tension between the goals of providing quality patient care and containing costs. See generally E. Hirshfeld, *The Case for Physician Direction in Health Plans*, 3 Annals of Health Law 81 (1994). Physician-controlled health plans hold this promise because physicians' decisions are already governed by professional ethical codes and obligations, see American Medical Ass'n, *Principles of Medical Ethics* (1994), and by the law of medical malpractice. Notwithstanding these pre-existing

ethical and legal constraints, the court of appeals found that ERISA also regulates the extent to which physicians may share in the financial consequences of their treatment decisions.

All of this damage is achieved by a vast and unwarranted expansion of the scope of fiduciary liability under ERISA. An entity is a fiduciary only "to the extent" that it has "discretionary authority or discretionary responsibility in the administration of [an ERISA] plan." 29 U.S.C. § 1002(21)(A). HMOs and other health care providers make myriad discretionary judgments when establishing and operating a health care plan, including an ERISA plan. Many such judgments -- including the cost-containment mechanism adopted -- have no direct impact on the benefits provided by an ERISA plan. Numerous HMO decisions -- *e.g.*, a decision to require pre-approval by the plan of hospital admissions or referrals outside a defined network of providers -- might in a particular case result in a reduction in the quality of benefits under a plan or affect a provider's judgment about when and where an enrollee should receive medical services. But it simply makes no sense to characterize all such ordinary and discretionary business judgments involved in establishing and operating a plan as "fiduciary." If all such judgments are fiduciary, the federal courts must now distinguish between "good" cost-containment measures and "bad" ones, (App. 58a (Easterbrook, J., dissenting)), a task for which courts are ill-equipped and, more importantly, a task which Congress has not committed to them. Moreover, treating all such judgments as fiduciary may well have the effect of withdrawing from state regulation and state courts medical malpractice cases in which the provider's judgment is alleged to have been affected by a plan's cost-containment measures.

The court of appeals was equally wrong to conclude that Herdrich stated a claim for breach of fiduciary duty merely by alleging that an HMO gives physicians bonuses based on

successful financial performance. Herdrich asserts only that adoption of a cost-containment incentive which gives an HMO or an HMO physician divided loyalties -- to patient/beneficiaries on the one hand and to financial gain on the other -- is inherently a breach of fiduciary duty. But that is not the law under ERISA. To the contrary, ERISA expressly *permits* the same person or entity to act as a fiduciary in one context and in service of self-interest in another. For example, an employer may seek to increase its profits by reducing the costs associated with providing benefits when it acts as plan sponsor or plan designer, while simultaneously having a duty to determine eligibility for, and provide, benefits under an extant plan solely in the interest of plan participants and beneficiaries. See, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 762-63 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890-91 (1996). Analogously here, the business judgments that help shape the design of a health care plan may be made with cost containment in mind, while benefit eligibility and delivery decisions are made with fiduciary loyalty. Far from violating ERISA, this duality is contemplated by ERISA's definition of fiduciary.

If Herdrich's allegations suffice to state a claim for fiduciary breach, then many, if not most, HMOs are unlawful, and a method of health care delivery authorized by Congress may not be utilized in ERISA welfare plans. Health plans owned by physicians or other health care providers are particularly at risk. This Court's review is warranted to correct the court of appeals' erroneous and damaging interpretation of ERISA.

I. THE COURT OF APPEALS' DECISION IS OF NATIONAL IMPORTANCE AND WILL HAVE AN IMMEDIATE, WIDESPREAD, AND DAMAGING IMPACT

A. Traditionally, health care in the United States was provided on a fee-for-service basis, and physicians and other providers of medical services were separate from the entities responsible for paying for that health care (usually, insurers). A physician provided a treatment; bills were submitted to an insurer, which paid those bills pursuant to the terms of the insurance contract. In the late 1960s and early 1970s, rapid and dramatic increases in health care costs led to the development of alternative forms of health care delivery and financing including HMOs, preferred provider organizations, and other forms of "managed care."

Generally, in a managed care plan, enrollees receive comprehensive health care coverage in exchanged for a fixed premium. The plan arranges for the enrollees' care by employing or contracting with providers. Costs are controlled through a variety of administrative mechanisms, such as utilization review, medical necessity determinations, and pre-certification of care. See, *e.g.*, *American Mfrs. Mut. Insurance Co.* v. *Sullivan*, 119 S. Ct. 977, 982-83 (1999); *FTC* v. *Indiana Federation of Dentists*, 476 U.S. 447, 449 (1986). Often these devices are linked with financial incentives to encourage increased patient volume for participating providers and reduced reliance on non-participating providers.[4] Such mechanisms are now routinely used to contain health care costs.

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[4] D. C. McGraw, *Financial Incentives to Limit Services: Should Physicians be Required to Disclose these to Patients?* 83 Geo. L.J. 1821, 1821 (1995) (citing Stanley S. Wallack, *Managed Care: Practice, Pitfalls and Potential*, Health Care Financing Rev. 1991, Ann. Supp. 27).

U.S. General Accounting Office, GAO/HRD-94-3, *Managed Health Care – Effect on Employers' Costs Difficult to Measure* 4-5 (1993).[5] Indeed, a substantial majority of HMOs use financial rewards and penalties for health care providers to promote cost-effective treatment.[6] At issue in this case is whether employer-sponsored health plans governed by ERISA may use these commonplace mechanisms for financing and delivering health care for their participants and beneficiaries.

Congress has encouraged the development of health care delivery systems in which providers bear or share in the gains or losses of the plan. In 1972, Congress enacted the Health Maintenance Organization Act, 42 U.S.C. § 300e. The HMO Act requires HMOs to assume financial risk for the care of enrollees. Further, it specifically authorizes HMOs to place some or all of this risk on the doctors and other health care professionals providing its services:

> Each [HMO] shall . . . assume full financial risk on a prospective basis for the provision of basic health services, except that a[n] [HMO] may . . . make arrangements with physicians or other health professionals, health care institutions, or any combination of such individuals or institutions to assume all or part of the financial risk on a prospective basis for the provision of basic health services by the physicians or other health professionals or through the institutions. [42 U.S.C. § 300e(c).]

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[5] *See also* D. McGraw, *supra*, at 1823 & n.12.

[6] *See* GAO Report, *supra*, at 30; D. McGraw, *supra*, at 1827 n. 39 (citing M. Rodwin, *Medicine, Money and Morals* 140 (1993)).

Likewise, Congress has encouraged the development of managed care options in the Medicare and Medicaid programs. See 42 U.S.C. § 1395mm (Medicare managed care); 42 U.S.C. § 1396b(m) (Medicaid managed care). Indeed, in the Balanced Budget Amendments of 1997, Congress specifically authorized Medicare to contract for delivery of care from risk-bearing "provider-sponsored organizations" -- entities formed by physicians or hospitals -- even if those entities do not otherwise meet the requirements of state insurance and HMO laws. See Act of Aug. 14, 1935, Pub. L. No. 74-271, ch. 531, § 1855, 49 Stat. 620 (codified as amended at 42 U.S.C. § 1395w-25). These initiatives demonstrate a congressional commitment both to development of alternative delivery systems and to the direct financial participation of physicians and other health care providers in those systems.

B. In Count III of her complaint, Herdrich alleged that petitioners breached their fiduciary duty under ERISA by establishing a cost-containment mechanism which provided physicians with a "year-end distribution" based on the savings achieved by cost containment. Thus, she alleges that financially rewarding a group of physicians for successful cost containment in the provision of health benefits is a breach of fiduciary duty under ERISA. The court of appeals held (i) that petitioners were acting as fiduciaries when they established the cost-containment mechanism, including the financial rewards for physicians; and (ii) that the allegation that petitioners had such a mechanism in place states a claim for breach of fiduciary duty. This is a decision with a significant and potentially devastating impact on an industry -- health care -- of unquestioned national importance.

If the court of appeals' decision is accepted, then "the principal organizational forms through which medical care is delivered today are unlawful." App. 56a (Easterbrook, J.,

dissenting) "Most medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option." *Id.* (Easterbrook, J., dissenting). See also *supra*, at 13-14 nn.4 & 5. The court of appeals' decision thus will reverberate throughout the health care sector of the economy. See D. Temchine, *Seventh Circuit's ERISA Fiduciary Duty Ruling*, Health L. Rep. (BNA) No. 36, at 1421 (Sept. 3, 1998) (*Herdrich* is a "frontal attack on managed care organizations' . . . cost-containment measures").

While petitioners' plan is owned by physicians, the court of appeals decision has far-reaching implications for all managed care plans. As Judge Easterbrook explained in his dissent from denial of rehearing *en banc*, the court of appeals' holding is "impossible to cabin, for the plan attacked in this case is an ordinary HMO":

> *If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations.* Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." Unlike some other HMOs, [petitioners' HMO] is owned by its physicians, but I do not think that this makes a legal (or practical) difference. Physicians own much of the stock of HMOs organized as corporations or receive some of its profits as bonuses or salary increments; and no matter the HMO's internal organization, the benefit to a particular physician from a particular treatment decision is minuscule. [App. 57a (emphasis supplied).]

The immediate, practical consequences of the decision are grave. Any ERISA plan employing financial rewards or penalties for cost containment is now subject to a federal suit seeking relief for an ERISA violation, including attorneys' fees. And if the court of appeals' decision is left unreviewed, such mechanisms would become unlawful and subject to judicial injunction. Extant plans would have to be scrapped and reworked. Indeed, under this decision, any cost-savings achieved by managed care would be lost. App. 56a (Easterbrook, J., dissenting). Many employers that provide health care as part of employees' benefit packages will have to rethink the terms of their employees' health benefits and compensation packages. The decision will thus alter the provision of managed care in Illinois, Indiana and Wisconsin and, more generally, will cut a costly, disruptive swath through the nation's health care industry and through the general economy.

The decision also has important consequences for Congress and the federal judiciary. In effect, the decision bypasses an express congressional authorization of managed care, including an explicit provision allowing HMOs to use methods of physician compensation that financially reward physicians for minimizing the cost of care and financially penalize physicians for failing to do so. See 42 U.S.C. § 300e(c).[7] The court of appeals has also effectively preempted the current debate about managed care in Congress and in the

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[7] *See also* 42 C.F.R. § 417.479 (addressing financial incentives in the Medicare and Medicaid contexts).

States (App. 24a-29a, 31a-32a) by incorrectly ruling that many, if not most, cost-containment mechanisms are unlawful. See also generally, U.S. Dep't of Health & Human Servs., *State Regulatory Experience With Provider-Sponsored Organizations* (1997).

The decision further assigns to the federal judiciary the task of determining whether specific cost-containment mechanisms are desirable or undesirable, "commit[ting] the court[s] to a long (and I should think unhappy) course of distinguishing 'good' managed-care systems from 'bad' ones." See App. 58a (Easterbrook, J., dissenting). And, under this ruling, federal courts will assume from state courts some significant part of the burden of medical malpractice cases. This is traditionally a matter for state regulation. *E.g.*, *New York Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 657-58 (1995). Under the court of appeals decision, however, a claim of medical malpractice based, in whole or in part, on cost-containment incentives in an employer-sponsored health plan is transformed (via ERISA) into a claim for breach of fiduciary duty. Of course, the judiciary makes many judgments in specialized areas when the Constitution or the Congress requires it to do so, but the court of appeals had to stretch ERISA out of its natural shape in order to appropriate these policy judgments for federal courts. These harmful consequences are the result of the court of appeals' incorrect interpretation of ERISA.

II. THE DECISION OF THE COURT OF APPEALS IS WRONG AND IN SUBSTANTIAL TENSION WITH DECISIONS OF THIS COURT.

A. *An HMO And Its Physicians Do Not Act As Fiduciaries By Implementing Cost-Containment Incentives.*

The court of appeals held that petitioners were acting as fiduciaries when they adopted a cost-containment mechanism that financially rewards physicians for the plan's successful cost containment. Under ERISA,

> a person is a fiduciary with respect to a plan *to the extent* (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan. [29 U.S.C. § 1002(21)(A) (emphasis supplied).]

A person is a fiduciary only "to the extent" that he or she is engaged in one of the defined activities. When that person is engaged in other activities that involve the exercise of discretion, he or she is not acting as a fiduciary, even though that exercise of discretion may substantially affect the plan. Thus, for example, an employer is not acting as a fiduciary when it selects a plan's terms or modifies or terminates the plan, even

though that same employer is a fiduciary when administering the plan. See, *e.g.*, *Hughes Aircraft Co.* v. *Jacobson*, 119 S. Ct. 755, 763 (1999); *Lockheed Corp.* v. *Spink*, 517 U.S. 882, 890 (1996).

As the court of appeals recognized, petitioners do not control the State Farm plan's assets. But, it concluded, petitioners have "discretionary authority or discretionary control respecting management of such plan" and "discretionary authority or discretionary responsibility in the administration of such plan." App. 12a (internal quotation marks omitted). The critical question, however, is not whether petitioners are *ever* ERISA fiduciaries, but whether petitioners acted as fiduciaries when they "establish[ed] one set of cost-saving incentives rather than another."[8] *Id.* at 53a (Easterbrook, J., dissenting). As Judge Easterbrook cogently explained, an HMO's discretionary selection among different types of cost-saving mechanisms should not be deemed an exercise of discretion "'in the administration of [the] plan.'" *Id.* (alteration in original).

Initially, the adoption of cost-containment measures which are incorporated in the terms of an ERISA plan is clearly a plan design decision. Equally clearly, then -- and contrary to the court of appeals -- neither State Farm nor petitioners were acting as fiduciaries when they agreed on the terms of the plan and included in that plan cost-containment measures, such as limitations on "the doctor referral process, the nature and duration of patient treatment, and the extent to which

[8] The court of appeals also appears to have believed that petitioners can be characterized as ERISA fiduciaries for all purposes if they are ERISA fiduciaries for any purpose. *See, e.g.*, App. 14a ("[w]e can reasonably infer that [petitioners] were plan fiduciaries due to their discretionary authority in deciding disputed claims"). That position is flatly contradicted by this Court's holdings in *Hughes Aircraft Co.* and *Lockheed Corp.*

participants were required to use Carle-owned facilities." App. 14a (emphasis omitted). See *Hughes Aircraft Co.*, 119 S. Ct. at 763-64; *Lockheed Corp.*, 517 U.S. at 890-91.

The HMO's further decision to provide financial incentives for physicians to implement the cost-containment measures set forth in the plan also is not a fiduciary act. It does not alter or in any way directly affect the terms of a plan or a participant's entitlement to benefits under the plan. Here, for example, participants and beneficiaries covered by the State Farm plan are entitled to the health care benefits set forth in the Member Subscription Certificate (attached to Herdrich's complaint as Exhibit A (App. 89a-128a)). Herdrich does not -- and could not -- allege that petitioners enacted a cost-saving mechanism or policy that alters the terms of the plan or directly deprives a participant of benefits provided by the plan. Quite to the contrary, as the amended complaint and the plan attached thereto reflect, *the cost-saving features that Herdrich objects to are embodied in the terms of the plan itself.*

Herdrich alleged -- and the court of appeals concluded -- that petitioners' adoption of financial rewards for successful cost containment *may indirectly affect* a participant's benefits and therefore that the decision to adopt such rewards constitutes "management" or "administration" of a plan -- a fiduciary act. More specifically, Herdrich alleged that a cost-saving mechanism that financially rewards physicians may induce physicians not to provide the health care benefits set forth in the plan or to provide lower quality benefits, resulting in an indirect impact on the plan.

The words "management" and "administration" should not be interpreted so expansively as to embrace any act that may indirectly affect benefits provided under an ERISA plan. Such an interpretation would dramatically increase the scope of

fiduciary responsibility. In addition, the scope of fiduciary responsibility would become even more ill-defined, as federal courts struggle to determine how much indirect impact a business judgment must have on benefits before it can be characterized as fiduciary in nature. Cf. *Varity Corp.* v. *Howe*, 516 U.S. 489, 539 (1996) (explaining that an employer is not acting as a fiduciary simply "because 'an ordinary business decision turn[ed] out to have an adverse impact on the plan'").

Health care professionals and institutions that provide benefits under ERISA plans make numerous business and clinical judgments that may indirectly affect such benefits. All businesses, including health care providers, seek to control costs; virtually any cost-saving decision may indirectly affect benefits. For example, if a managed care organization were to decide to pay hospitals a set fee per in-patient admission, regardless of the patient's length of stay, that arrangement would financially reward the hospital for treating a large number of patients and discharging them as quickly as possible. Similarly, a group of physicians contracting with a health plan might decide not to invest in an expensive piece of medical equipment, even though purchasing the equipment might improve care for plan participants. Such decisions inherently involve a careful balancing of business and clinical considerations.

On the court of appeals' theory, each of these judgments and numerous others are fiduciary in nature, and federal courts must decide whether such judgments breach a fiduciary's duty to make decisions with an "eye single" to the interests of participants. See *Donovan* v. *Bierwirth*, 680 F.2d 263, 271 (2d Cir. 1982) (Friendly, J.). That theory puts federal judges in the difficult and uncomfortable business of determining (i) how direct and substantial an effect on plan benefits is required before a business judgment is deemed fiduciary, and (ii) whether

a fiduciary judgment that a particular cost-saving mechanism should be adopted is, in the circumstances, in the overall best interest of plan beneficiaries. Properly interpreted, however, ERISA does not require federal courts to enter this thicket. Judgments that only potentially and indirectly affect benefits under an ERISA plan do not constitute management or administration *of the plan* and thus are not fiduciary in nature.

This Court's recent decisions in the closely related context of ERISA preemption confirm that the HMO judgments at issue here are not fiduciary in nature. ERISA preempts any state law that "relate[s] to" an ERISA benefit plan. See 29 U.S.C. § 1144(a). This Court has twice recently held that state laws which have an *indirect* economic impact on ERISA plans and which may therefore *indirectly* affect plan administration do not "relate to" an ERISA plan and thus are not preempted. See *New York Conference of Blue Cross & Blue Shield Plans* v. *Travelers Insurance Co.*, 514 U.S. 645, 659 (1995) ("[a]n indirect economic influence, however, does not bind plan administrators to any particular choice and thus function as a regulation of an ERISA plan itself"); *DeBuono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 815-16 (1997) (a state law which "increases the cost of providing benefits to covered employees will have some effect on the administration of ERISA plans," but nonetheless does not "relate to" an ERISA plan).[9] If an act having an indirect economic influence on plan administration does not "relate to" an ERISA plan, *a fortiori* a judgment which may have indirect economic influence on a plan does not constitute "management" or "administration" of a plan.

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[9] *Cf. Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 837-41(1988) (explaining that a law operating as an indirect source of merely economic influence on administrative decisions should not suffice to trigger preemption).

It is, of course, "possible to read 'in the administration of [the] plan' broadly in order to catch all discretionary elements of the HMO structure." App. 53a (Easterbrook, J., dissenting) (alteration in original). But this is not the most natural reading of ERISA and it threatens to derail virtually any attempt to implement cost-containment strategies:

> [W]hy should courts do this? In order to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure (or that participants will select it from among options the plan offers)? The panel's opinion sounds very much like this is the objective: its lengthy condemnation of managed care, 154 F. 3d 373-79, otherwise is hard to understand. [*Id.* (Easterbrook, J., dissenting).]

Congress has authorized such cost-saving experiments, and its explicit choice should not be overruled by an overly broad reading of ERISA's definition of a fiduciary.

The court of appeals' decision also effectively deprives plan sponsors of the right to establish an ERISA welfare plan providing benefits through an HMO or other managed care option. This Court's decisions in *Hughes Aircraft Co.* and *Lockheed Corp.* hold that employers making ERISA plan-design decisions are not acting as fiduciaries and thus may select an HMO or other managed care option as a benefit provider, just as State Farm did here. But the "right" to make such a selection means little "if implementing the HMO itself violates ERISA." App. 54a (Easterbrook, J., dissenting). "What the panel has held comes to the same thing -- though by a different route -- as saying that welfare benefit plans have a fiduciary

duty not to adopt HMO or other managed-care options." *Id.* (Easterbrook, J., dissenting).

In sum, numerous business and clinical judgments made by an HMO or its physicians may, in particular instances, have some indirect effect on benefits. But such judgments do not alter a plan or deprive any participant or beneficiary of plan benefits. They therefore are *not* exercises of discretion in the "management" or "administration" of a plan resulting in fiduciary liability, but rather "exercise[s] of managerial discretion in the administration of [an HMO's] business." App. 53a (Easterbrook, J., dissenting). Because of the potentially devastating consequences of the court of appeals decision, certiorari review is warranted.

B. *An Allegation That An HMO Financially Rewards Physicians For Successful Cost-Containment Does Not State A Claim For Breach Of Fiduciary Duty*

In amended Count III of her complaint, Herdrich alleges that the same administrators:

> vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who become eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (*i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs

so as to ensure larger bonuses. [App. 18a (emphasis omitted).]

The claim is that petitioners breached their fiduciary duty because they provided annual financial rewards to their physicians for successful implementation of cost-saving measures.

The court of appeals held that this allegation by itself states a claim under ERISA. Specifically, the court of appeals concluded that -- notwithstanding a physician's ethical obligations and the specter of medical malpractice suits -- the allegation that a physician receives a financial reward at the end of the year based on the plan's overall profit margin is adequate to support an inference that a physician may deny an individual patient/beneficiary medical treatment to which he or she is entitled under an ERISA plan. Most HMOs, however, reward physicians in some way for successfully containing costs, whether through bonuses or incentives or increases in salaries. Indeed, "[p]hysicians own much of the stock of HMOs organized as corporations or receive some of its profits as bonuses or salary increments; and no matter the HMO's internal organization, the benefit to a particular physician from a particular treatment decision is minuscule." App. 57a (Easterbrook, J., dissenting).

"If [petitioners'] setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations." App. 57a (Easterbrook, J., dissenting). The cost-containment mechanism alleged -- limiting care to specified doctors and locations, limiting referrals for specialized treatment, charging per patient fees, and "reaping for the HMO's owners the benefits of reduced health-care expenditures," *id.* (Easterbrook, J., dissenting), are the principal and characteristic features of

HMOs and other managed care organizations. Indeed, the plan document (the Group Subscription Certificate) itself recites that petitioners employ cost-saving measures.[10]

The court of appeals, however, has ruled that plan fiduciaries may not lawfully make the judgment that adoption of cost-containment incentives for physicians is in the overall best interest of plan participants and beneficiaries. Reasonable people can and do differ about the relative efficacy and benefits of fee-for-service and managed care systems for health care delivery. But the court of appeals' decision is, as explained above, inconsistent with *Congress'* authorization of HMOs and of financial consequences for health care providers' treatment decisions. See *supra*, at 10.

In addition, the court of appeals' decision is in fundamental tension with decisions of this Court. Herdrich alleged -- and the court of appeals found -- that petitioners' provision of financial rewards to physicians for successful cost containment is unlawful simply because it creates divided loyalties in physicians when they are making health care eligibility and treatment decisions under the plan. But an allegation of divided loyalties is insufficient to state a claim for breach of fiduciary duty under ERISA. ERISA makes this clear by defining a person as a fiduciary only "to the extent that" the person is making discretionary judgments under the plan. See *Varity Corp.*, 516 U.S. at 498 (comparing ERISA's authorization of dual loyalties with *NLRB* v. *Amax Coal Co.*, 453 U.S. 322, 329-30 (1981) ("common law of trusts prohibits fiduciaries from holding positions that create a conflict of interest with trust beneficiaries")). Congress and this Court thus have both made clear that a person who is an ERISA fiduciary

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[10] *See supra*, at 4 n.1

in one setting may singlemindedly pursue his or her self-interest in another setting without breaching any fiduciary obligation under ERISA. See *Hughes Aircraft Co.*, 119 S. Ct. at 763; *Lockheed Corp.*, 517 U.S. at 890. See also ERISA § 408(c)(3), 29 U.S.C. §1108(c)(3) (an employer may act as plan sponsor and plan administrator).

Under ERISA, for example, an employer decides what benefits to offer and makes plan design and modification decisions unencumbered by fiduciary obligations under ERISA; in so doing, the employer may keep its eye firmly fixed on the bottom line. That same employer must make coverage and eligibility decisions under the plan as a fiduciary with an "eye single" to the interests of the patient/beneficiaries. See, *e.g.*, *Hughes Aircraft Co.*, 119 S. Ct. at 763 ("an employer's decision to amend a pension plan concerns the composition or design of the plan itself and does not implicate the employer's fiduciary duties which consist of such actions as the administration of the plan's assets"). Analogously here, an employer may decide to provide health benefits through an HMO. The HMO employs cost-containment mechanisms and makes other business judgments with an eye to increasing its profits. That same HMO, however, must make coverage and eligibility decisions under the plan with an "eye single" to the interests of the patient/beneficiaries. Cf. App. 58a (Easterbrook, J., dissenting) ("Lawyers owe fiduciary duties to their clients. Can it be that the incentive given by the partnership's reward structure to substitute the services of associates for those of partners creates a conflict of interest that invariably violates those duties? If the answer is 'no' for law firms (and that must be the right answer), it is 'no' for HMOs, in stock or partnership form").

Unlike the common law of trusts, ERISA contemplates that persons acting as ERISA fiduciaries may have such divided loyalties. Accordingly, the bare allegation that petitioners have

divided loyalties does not state a claim for breach of fiduciary duty under ERISA.[11] The immediate and substantial damage done to an important national industry by the court of appeals' contrary ruling amply justifies certiorari review.

CONCLUSION

The petition for certiorari should be granted.

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[11] *See, e.g., Weiss* v. *CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 753 (S.D.N.Y. 1997) ("Weiss' contention that CIGNA's compensation package [for physicians] facially violates ERISA simply because it deprives her of her right to receive 'medical opinions and referrals unsullied by mixed motives,'. . .is tantamount to a claim that risk-sharing arrangements in managed care are inherently illegal, a position that is refuted by federal and New York law. *See* 42 U.S.C. § 300(e)(2); 42 C.F.R. §417.103(b); N.Y. Pub. Health Law §4403(1)(c). Moreover, plaintiff's concern about the soundness of managed care policy is best suited for resolution by branches of government other than the judiciary.").

Respectfully submitted,

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June 4, 1999

APPENDICES

APPENDIX A

Cynthia HERDRICH, Plaintiff-Appellant,

v.

Lori PEGRAM, M.D., Carle Clinic Association, and Health Alliance Medical Plans, Incorporated, Defendants-Appellees.

No. 97-1070.

United States Court of Appeals,
Seventh Circuit.

Argued Dec. 2, 1997.
Decided Aug. 18, 1998.

Before WOOD, JR., COFFEY and FLAUM, Circuit Judges.

COFFEY, Circuit Judge.

The defendants-appellees, Carle Clinic Association, P.C. ("Carle"), Health Alliance Medical Plans, Inc. ("HAMP"), and Carle Health Insurance Management Co., Inc., operate a pre-paid health insurance plan which provides medical and hospital services. The plaintiff-appellant, Cynthia Herdrich ("Herdrich"), was covered under a plan subscription through her husband's employer, State Farm Insurance Company, an Illinois corporation. In March of 1992, Herdrich's appendix ruptured as the result of alleged improper medical treatment while she was in the care of Dr. Lori Pegram ("Pegram"), a physician who

practiced under the plan.[1] On October 21, 1992, Herdrich filed a two-count complaint, alleging medical negligence against the health plan operators. Herdrich later added counts III and IV, alleging state law fraud. The defendants, in response, contended that the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. §§ 1001 *et seq.*, preempted counts III and IV, and successfully removed the case to federal court. They subsequently filed a motion for summary judgement as to counts III and IV. The trial judge granted the summary judgement motion on count IV only, and gave Herdrich leave to amend count III. In accordance with the court's instructions, Herdrich amended count III to allege that the defendants had breached their fiduciary duty to plan participants, in violation of ERISA. The defendants moved to dismiss the amended count III for failure to state a claim upon which relief could be granted. The court agreed and granted the motion. The remaining two medical negligence counts (I and II) went to trial before a jury. Herdrich prevailed on both of them. Thereafter, she filed a notice of appeal as to the trial court's dismissal of her amended count III. We reverse and remand this case to the district court (on count III) for a trial.

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[1] On March 1, 1991, Dr. Pegram examined Herdrich, and acknowledged that she (Herdrich) was experiencing pain in the midline area of her groin. Six days later, March 7, Dr. Pegram discovered a six by eight centimeter inflamed mass in Herdrich's abdomen. In spite of the fact that Herdrich's appendix was noticeably inflamed on March 7, Pegram required her to wait eight more days before undergoing the necessary diagnostic procedure (ultrasound) at a Carle-staffed facility more than fifty miles away in Urbana, Illinois, rather than allowing the procedure to be performed at her local hospital in Bloomington, Illinois. It was during this eight-day waiting period that Herdrich's appendix ruptured, resulting in peritonitis.

I. BACKGROUND

This appeal arises out of a complaint filed by Herdrich in the Circuit Court of McLean County, Illinois, on October 21, 1992, against Lori Pegram, M.D. and Carle Clinic Association. Counts I and II of the plaintiff's complaint were based upon a theory of professional medical negligence. Specifically, Herdrich alleged that she suffered a ruptured appendix and, in turn, contracted peritonitis due to Pegram's negligence in failing to provide her with timely and adequate medical care. On February 18, 1994, Herdrich was granted leave to amend the complaint. In her amended complaint, she added two counts (III and IV) of state law fraud against Carle and Health Alliance Medical Plans, Inc.[2] The defendants removed the case to federal court, asserting that the two new counts were preempted by ERISA, and thereafter filed a motion for summary judgment as to counts III and IV only. The court granted summary judgement against Herdrich on count IV "to the extent [she] relies on § 502(a)(3)(B) [of ERISA] as a basis for monetary relief, as opposed to equitable relief," and that provision does not provide for extra-contractual damages. While the trial judge denied the defendants' summary judgment motion as to count III, he did conclude ERISA preempted that count, and granted Herdrich "leave to submit an amended

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[2] In count III, Herdrich asserted that Carle Clinic violated the Illinois Consumer Fraud Act, 815 ILCS 505/1. *et seq.*, by failing to disclose certain material facts regarding the ownership of HAMP, as well as failing to advise her that the compensation of plan physicians was increased to the extent that they did not order diagnostic tests, utilized facilities owned by those physicians, and did not make emergency or consultation referrals. Count IV alleged that HAMP breached its duty of good faith and fair dealing by increasing its profits and the profits of its contracted physicians through minimizing the use of diagnostic tests, emergency consultation referrals, and facilities now owned by such physicians, all to the detriment of plan beneficiaries.

Count III which clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision." On September 1, 1995, Herdrich filed her amended count III in accordance with the court's instructions. In it, she averred that the defendants breached their fiduciary duty to plan beneficiaries by depriving them of proper medical care and retaining the savings resulting therefrom for themselves.[3] The defendants

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[3] Herdrich's amended count III made the following allegations, among others:

5. In March of 1991 and thereafter, plaintiff's husband was employed by State Farm Mutual Automobile Insurance Company (hereinafter "State Farm").

6. Prior to March of 1991 and annually thereafter, for valuable consideration, through State Farm, defendants sold plaintiff a subscription in CARLE CARE HMO, a pre-paid health insurance plan (hereinafter "the Plan") arranging medical and hospital services for subscribers . . . .

7. State Farm retained no right to direct or control the administration of the Plan.

8. Defendants have the exclusive right to decide all disputed and non-routine claims under the Plan.

9. Under the Plan, defendants exercise discretionary authority and discretionary control of claims management, property and asset management, and administration of the Plan.

10. Defendant [sic] is a participant and beneficiary under the Plan and brings this action on behalf of the Plan pursuant to 29 U.S.C. § 1132(a).

11. Defendants are fiduciaries with respect to the Plan and under 29 U.S.C. § 1109(a) are obligated to discharge their duties with respect to the Plan solely in the interest of the participants and beneficiaries and

a. for the exclusive purpose of:

i. providing benefits to participants and their beneficiaries; and

ii. defraying reasonable expenses of administering the Plan;

b. with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and like aims.

12. In breach of that duty:

a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and

(continued...)

thereafter moved, pursuant to Rule 12 of the Federal Rules of Civil Procedure, to dismiss Herdrich's amended count III for failure to state a claim upon which relief could be granted.

By agreement, the case—including the defendants' motion to dismiss—was assigned to a magistrate judge, who recommended that the amended count III be dismissed because, in his opinion, "[t]he plaintiff fail[ed] to identify how any of the defendants is involved as a fiduciary to the Plan." He did, however, recommend that the court afford Herdrich "one last opportunity" to re-plead her claim under ERISA. Herdrich promptly filed a Rule 72 objection to the magistrate's recommendation. Less than two weeks later, on April 15, 1996,

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[3] (...continued)

CHIMCO;

b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

(1) minimize the use of diagnostic tests;

(2) minimize the use of facilities not owned by CARLE; and

(3) minimize the use of emergency and non-emergency consultation and/or referrals to noncontracted physicians.

ii. by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;

(2) what the applicable standard of care is;

(3) whether a course of treatment is experimental;

(4) whether a course of treatment is reasonable and customary; and

(5) whether a medical condition is an emergency.

13. As a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses made by HAMP and CHIMCO to CARLE, as well as those amounts which would have been realized by prudently investing those supplemental medical expenses.

the district court denied that objection and adopted the magistrate's recommendation as to count III. In so doing, it gave Herdrich 21 days from the entry of the order to re-plead her claim. Herdrich chose not to re-plead and stood on count III as amended.

The remaining counts, I and II, went to trial in early December 1996, and the jury returned a verdict in Herdrich's favor on both counts, awarding her $35,000 in compensatory damages. She then appealed the district court's earlier dismissal of her amended count III.

II. ISSUES

On appeal, Herdrich contends that the district court erred in dismissing the amended count III of her complaint for failing to sufficiently state a claim for breach of a fiduciary duty under ERISA. The defendants contend that we lack jurisdiction to hear this case due to Herdrich's failure to file a timely notice of appeal from the order of dismissal, entered April 15, 1996. The defendants further argue that Herdrich's request for damages is inappropriate insofar as beneficiaries under an ERISA benefits plan may not recover "anything other than the benefits provided expressly in the plan."

III. DISCUSSION

A. *Jurisdiction*

As an initial matter, we are called upon to determine whether or not we have jurisdiction to hear this appeal. The defendants contend that Herdrich's failure to file a notice of appeal within thirty days from the district court's April 15, 1996,

order of dismissal leaves us without jurisdiction. *See* Fed. R.App. P. 4(a)(1) ("[I]n a civil case in which an appeal is permitted by law as of right from a district court to a court of appeals the notice of appeal . . . must be filed with the clerk of the district court within 30 days after the date of entry of the judgment or order appealed from."). Alternatively, the defendants urge that jurisdiction is improper because the April 15 order was not a "final decision" for purposes of appealability, as required by 28 U.S.C. § 1291. We disagree and think it clear that Carle and HAMP have misconstrued the law in relation to both of their arguments.

This court has jurisdiction to hear appeals from the "final decisions" of the federal district courts. 28 U.S.C. § 1291. A "final" decision is defined as one that terminates the litigation. *See Catlin v. United States*, 324 U.S. 229, 233, 65 S.Ct. 631, 633, 89 L.Ed. 911 (1945). 28 U.S.C. § 1292 also gives us jurisdiction over appeals from specified interlocutory orders.[4]

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[4] U.S.C. § 1292 provides, in relevant part:

(a) . . . the courts of appeals shall have jurisdiction of appeals from:

(1) Interlocutory orders of the district courts of the United States . . ., or of the judges thereof, granting, continuing, modifying, refusing or dissolving injunctions, or refusing to dissolve or modify injunctions, except where a direct review may be had in the Supreme Court;

(2) Interlocutory orders appointing receivers, or refusing orders to wind up receiverships or to take steps to accomplish the purposes thereof, such as directing sales or other disposals of property;

(3) Interlocutory decrees of such district courts or the judges thereof determining the rights and liabilities of the parties to admiralty cases in which appeals from final decrees are allowed

(b) When a district judge, in making in a civil action an order not otherwise appealable under this section, shall be of the opinion that such order involves a controlling question of law as to which there is substantial ground for difference of opinion and that an immediate appeal from the order may materially advance the ultimate termination of the litigation, he

(continued...)

Generally speaking, interlocutory appeals are disfavored, and appellate courts are reluctant to exercise their discretion to grant such requests, as they all too frequently cause unnecessary delays in lower court proceedings and waste the resources of an already overburdened judicial system. *See Coopers & Lybrand v. Livesay*, 437 U.S. 463, 473-74, 98 S.Ct. 2454, 2460-61, 57 L.Ed.2d 351 (1978). For these reasons, the preferred practice is to defer appellate review until the entry of a final judgment in order that we might rule on *all* issues at one time. *See* 437 U.S. at 475, 98 S.Ct. at 2461. "[E]ven if the district judge certifies the order under § 1292(b), the appellant still has the burden of persuading the court of appeals that exceptional circumstances justify a departure from the basic policy of postponing appellate review until after the entry of a final judgment." *Id.* (citation and internal quotation omitted).

A trial court's order dismissing a complaint is not a final judgment for purposes of appeal under 28 U.S.C. § 1291 because it does not terminate the litigation. *See Paganis v. Blonstein*, 3 F.3d 1067, 1070 (7th Cir.1993) ("The dismissal of a compliant does not end the litigation. . . . In contrast, a dismissal of the entire action ends the litigation and forces the plaintiff to choose between appealing the judgment or moving to reopen the judgment and amend the compliant pursuant to Fed.R.Civ.P. 59 or Rule 60. . . . Therefore, if a judgment entry dismisses only the complaint, it is not a final judgement.") (internal citations and quotations omitted). This is particularly true when one or more counts of a multiple count complaint and/or indictment are dismissed for whatever reason, and others are left intact. In such cases, an interlocutory appeal of the dismissal order is available only after the order is certified by the district court under section 1292(b), *supra*, or by entry of a

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[4] (...continued)
shall so state in writing such order.

partial final judgement under Rule 54 of the Federal Rules of Civil Procedure. *See Principal Mut. Life Ins. Co. v. Cincinnati TV 64 Ltd. Partnership*, 845 F.2d 674, 676 (7th Cir.1988) (district court order granting judgment on one count but dismissing nine other counts without prejudice and expressly providing plaintiff right to reinstate seven counts was not final appealable order because it did not "terminate the litigation"). Just because the district court failed to take either of these two courses of action in the instant case does not mean we are without jurisdiction over this appeal, for the court's April 15 order of dismissal became final, and thus appealable, upon entry of final judgment on December 15, 1996.

Contrary to the jurisdictional claims made in the defendants' brief, an order which is not a final judgment when entered becomes final or appealable upon the entry of a final judgment. The appeal of this judgment renews all issues previously pleaded and resolved by the trial court in litigation. *See In the Matter of Grabill Corp.*, 983 F.2d 773, 775 (7th Cir.1993). In the case under consideration, the April 15, 1996, order dismissing Herdrich's amended count III was an interlocutory ruling, rather than a final decision, as it failed to dispose of all the issues before the court. That is, the plaintiff's counts I and II were not dismissed, and the litigation between Herdrich and the defendants was continuing. The trial court's order dismissing the plaintiff's amended count III did not become final until such time as the judgment was entered on December 5, 1996. Herdrich's appeal from the trial court's dismissal of count III of her complaint, filed on January 6, 1997, was timely in that she filed it within thirty days of the December 5 entry of judgment.

B. *The Plaintiff Properly Stated a Claim Under ERISA*

The defendants next contend that Herdrich has failed to state a cause of action for breach of a fiduciary duty under ERISA. As previously mentioned, the district court dismissed Herdrich's amended count III, finding that even as amended, the complaint did not state a claim upon which relief might be granted.

This court reviews dismissals of complaints *de novo*. *See Conley v. Gibson*, 355 U.S. 41, 45-46, 78 S.Ct. 99, 102, 2 L.Ed.2d 80 (1957). "In appraising the sufficiency of the complaint we follow, of course, the accepted rule that a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief." *Id.* A complaint must contain either direct or inferential allegations respecting all the material elements necessary to sustain a recovery under some viable legal theory. *See Sutliff, Inc. v. Donovan Cos., Inc.*, 727 F.2d 648, 654 (7th Cir.1984). But such allegations need only state a *possible* claim, not a winning claim. *See, e.g., Conley*, 355 U.S. at 45-46, 78 S.Ct. at 102; *Trevino v. Union Pac. R.R. Co.*, 916 F.2d 1230, 1234 (7th Cir.1990) ("The federal rules do not require a plaintiff to allege sufficient facts to establish his right to a judgment. All it requires [sic] . . . is a 'short and plain' . . . statement of what his claim is.") (quoting Fed.R.Civ.P. 8(a)(2)). And this court has steadfastly held that a plaintiff's complaint "need not plead facts or legal theories; it is enough to set out a claim for relief . . . ." *Nance v. Vieregge*, 147 F.3d 589, 590-91 (7th Cir.1998). Moreover, "[a] complaint may not be dismissed under Fed.R.Civ.P. 12(b)(6) just because it omits factual allegations . . . ." *La Porte County Republican Cent. Comm. v. Board of*

Comm'rs of the County of La Porte, 43 F.3d 1126, 1129 (7th Cir.1994).

ERISA is a statutory scheme which regulates all "private employee benefits plans, including both pension plans and welfare plans." *District of Columbia v. Greater Washington Bd. Of Trade*, 506 U.S. 125, 127, 113 S.Ct. 580, 582, 121 L.Ed.2d 513 (1992). The definition of a "welfare plan" includes "any plan, fund, or program" maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries "through the purchase of insurance or otherwise." *Id.* (quoting 29 U.S.C. § 1002(1)). Importantly, ERISA establishes uniform standards, including rules relating to "reporting, disclosure, and fiduciary responsibility." *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 137, 111 S.Ct. 478, 482, 112 L.Ed.2d 474 (1990) (citation omitted).

In order to properly state a claim for breach of fiduciary duty under ERISA, the plaintiff's complaint must allege facts which set forth: (1) that the defendants are plan fiduciaries; (2) that the defendants breached their fiduciary duties; and (3) that a cognizable loss resulted. *See* 29 U.S.C. § 1104(a). We are of the opinion that Herdrich's pleadings have more than sufficiently alleged each of these three elements.

1. *Fiduciary Status*

As previously explained, the district court adopted the magistrate judge's recommendation that Herdrich's amended count III be dismissed for failure to allege that the defendants were fiduciaries because "none of the defendants is even mentioned in the Subscription Agreement attached to the complaint" and "the plaintiff fails to identify how any of the

defendants is involved as a fiduciary to the Plan."[5] We disagree with this determination.

ERISA defines the term "fiduciary" in 29 U.S.C. § 1002(21)(A), which reads, in relevant part:

> Except as otherwise provided in subparagraph (B), a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority of control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

Congress, when it enacted ERISA, intended that this statutory definition of "fiduciary" be broadly interpreted. As stated by the Chairman of the House Committee on Education and Labor, 120 Cong. Rec. 3977, 3983 (February 25, 1974) *reprinted*, 2 Legislative History of the Employee Retirement Income Security Act of 1974 at 3293:

> The Committee has adopted the view that the definition of fiduciary is of necessity broad. . . . A fiduciary need not be a person with direct access to the assets of the plan . . . . Conduct alone may in an appropriate circumstance impose fiduciary

[5] During the pleading stage of this suit, the defendants and plaintiff took dramatically different positions from what they now argue on appeal concerning the issue of whether the defendants were plan fiduciaries. That is, Herdrich originally maintained that the defendants were not plan fiduciaries, while the defendants insisted that they were. In the parties' respective appellant briefs, however, the defendants contend that they are not fiduciaries of the Plan, whereas the plaintiff claims they are.

> obligations. It is the clear intention of the Committee that any person with a specific duty imposed upon him by this statute be deemed to be a fiduciary . . . .

Consistent with the expressed intent of Congress, this court has routinely construed the ERISA term, "fiduciary," broadly. *See Chicago Bd. Options Exch., Inc. v. Connecticut Gen. Life Ins. Co.*, 713 F.2d 254, 260 (7th Cir.1983) ("It is clear that Congress intended the definition of fiduciary under ERISA to be broad . . . ."). In so doing, we have emphasized the importance of discretionary control and authority in determining who is a plan fiduciary. *See Harris Trust and Sav. Bank v. Provident Life and Accident Ins. Co.*, 57 F.3d 608, 613 (7th Cir.1995). In *Harris Trust*, for example, an employee's daughter lost her health insurance coverage when her father's company, Specialty Brands, Inc., was acquired by Campbell Soup. *See id.* at 611-12. The employee's new health plan was funded by Campbell and merely administered by Provident Life Insurance. *See id.* In concluding that Campbell was the plan fiduciary, we emphasized that it was Campbell, not Provident, who retained the right to direct and control the claims procedures and practices, as well as the right to decide all disputed and non-routine claims:

> The undisputed evidence shows that the Campbell Plan was created and fully funded by Campbell. *Provident was simply hired to administer the claims process under Campbell's direction and control* in accordance with an Administrative Services Agreement. Pursuant to that agreement, *Campbell, not Provident, dictates the claims administration procedures and practices which are to be followed, and all benefits eligibility determinations must be made in accordance with*

> *those procedures and practices. Campbell also retains the right under the agreement to decide all disputed and non-routine claims.*

Id. at 613 (emphasis added). Thus, it was the *retention of control of the claims process* that brought about Campbell's fiduciary status.

In the case *sub judice*, the magistrate, in his report and recommendation, opined that "the plaintiff fails to identify how any of the defendants is involved as a fiduciary to the plan," and that the plaintiff's amended third count "merely repeats the statutory language of § 1109(a) with regard to fiduciaries." We do not agree that Herdrich's amended count III is as "bare-bones" as the magistrate characterizes it. Although the amended third count *does* repeat some of the statutory language of ERISA, it also alleges, as in *Harris Trust*, that the "*defendants have the exclusive right to decide all disputed and non-routine claims under the plan." The defendant-physicians managed the Plan, including the doctor referral process, the nature and duration of patient treatment, and the extent to which participants were required to use Carle-owned facilities. In fact, the board of directors consisted exclusively of the Plan physicians who were thus in control of each and every aspect of the HMO's governance, including their own year-end bonuses.* And, like in *Harris Trust*, Herdrich pleaded that the defendants had the exclusive right to decide all disputed and non-routine claims. In our view, this level of control satisfies ERISA's requirement that a fiduciary maintain "discretionary control and authority." We can reasonably infer that Carle and HAMP were plan fiduciaries due to their discretionary authority in deciding disputed claims.

In a last ditch effort, the defendants parrot the magistrate's observation that "none of the defendants is even

mentioned in the Subscription Agreement attached to the complaint," and contend that they are not fiduciaries of the Plan because they are not specifically named in the Plan instrument, pursuant to § 1102(a)(2) of ERISA.[6] But the fact of the matter is that HAMP *is* prominently identified in the first sentence on the first page of the Plan's Group Subscription Certificate. *See* Group Subscription Certificate ("Carle Care HMO, a product of Health Alliance Medical Plans, Inc., is organized as a health maintenance organization to do business as a prepaid health plan in Illinois and Indiana."). Moreover, a party's fiduciary status hinges not on whether it is named in the plan agreement, but rather on whether it satisfies the statutory definition of a fiduciary in section 1002(21)(A) of ERISA, quoted *supra p.* 369-70. Contrary to the defendants' assertion, and the magistrate's conclusion, Carle and HAMP are, in fact, fiduciaries.

2. *Breach of Fiduciary Duty*

Having determined that the defendants are fiduciaries under ERISA, we next consider whether the direct and inferential allegations contained in Herdrich's complaint are sufficient to establish the requisite breach of a fiduciary duty. An ERISA fiduciary must perform his duties in accordance with the standards set forth in 29 U.S.C. § 1104(a)(1), which provides:

> [A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—
>
> (A) for the exclusive purpose of:

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[6] Section 1102(a)(2) defines a "named fiduciary" as a party who is named in the plan.

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims . . . .

A fiduciary breaches its duty of care under section 1104(a)(1)(A) whenever it acts to benefit its own interests. See James F. Forden et. al., *Handbook on ERISA Litigation § 3.03[A]*, at 3-53 (1994) (collecting cases). For example, ERISA expressly prohibits fiduciaries from "deal[ing] with the assets of the plan in his own interest or for his own account," or "receiv[ing] any consideration for his own personal account from any party dealing with such plan in connection with a transaction involving the assets of the plan." 29 U.S.C. § 1106(b). The requirement that an ERISA fiduciary act "with an eye single to the interests of the participants and beneficiaries," *Donovan v. Bierwirth*, 680 F.2d 263, 271 (2d Cir.1982), is the most fundamental of his or her duties, and "must be enforced with uncompromising rigidity." *NLRB v. Amax Coal Co.*, 453 U.S. 322, 329-30, 101 S.Ct. 2789, 2794-96, 69 L.Ed.2d 672 (1981) (citation and internal quotation omitted). This duty, the violation of which subjects a fiduciary to liability under 29 U.S.C. § 1109,[7] is directed particularly at schemes "tainted by

[7] Section 1109(a) of ERISA provides:

Any person who is a fiduciary with respect to a plan who breaches any of (continued...)

a conflict of interest and thus highly susceptible to self dealing," *Lowen v. Tower Asset Management, Inc.*, 829 F.2d 1209, 1213 (2d Cir.1987), like the one at issue here.

We think a number of authorities are particularly instructive in assisting us to determine whether the allegations in Herdrich's complaint, and the logical inferences drawn therefrom, are sufficient to demonstrate that there was a breach of the defendants' fiduciary duty. In *Dasler v. E.F. Hutton & Co., Inc.*, 694 F.Supp. 624 (D.Minn.1988), for example, the defendant brokerage firm acted as fiduciary for a profit-sharing plan. In his complaint, the plaintiff-beneficiary of the plan alleged that the defendant breached its ERISA-based fiduciary duty by engaging in excessive securities trading on behalf of the plan. *See id.* at 632. The court agreed, finding "that defendants considered their own interests and commission income when making investment decisions for the plan." *Id.* Similarly, in *Amweiler v. American Elec. Power Serv. Corp.*, 3 F.3d 986, 991-92 (7th Cir.1993), this court held that the defendant fiduciary breached its duty of loyalty and care under ERISA when it misled its pension plan participants by failing to give them complete material information concerning the terms of reimbursement under the pension plan. And in *Shea v. Esensten*, 107 F.3d 625 (8th Cir.1997), the Eight Circuit concluded that the defendants therein, much like Carle and HAMP, breached their fiduciary duty by *failing to disclose to plan participants a secret incentive structure that provided*

[7] (...continued)

the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

financial rewards to primary care physicians who minimized their use of tests and referrals. See id. at 628-29.

The Northern District of Illinois, in *Ries v. Humana Health Plan, Inc.*, 1995 WL 669583 (N.D.Ill., 1995), faced facts similar to those at bar. In *Ries*, the defendant, Humana Health, obligated the participants in its health plan to fully reimburse the plan for the costs associated with his or her treatment if such costs were recovered, by way of settlement or judgment, from the party (other than the plan) who caused his or her injury or disease. *See id.* at *1. The plan generally provided coverage for 80 percent of costs, while plan participants were obligated to finance 20 percent. Although Humana routinely collected a full 80 percent reimbursement from participants, Humana was in fact not paying 80 percent of the covered medical expenses, because it covertly arranged to receive a substantial discount for its share of the charges, unbeknownst to the plan participants. *See id.* at *3. As a result, plan participants were paying more than 20 percent of the amounts received by the hospitals, and Humana was, in effect, recouping an additional bonus for itself by paying less than the 80 percent of the medical expenses, as set forth in the plan. The *Ries* court ruled that ERISA did not *"permit a plan insurer to recoup more from its insureds than it actually pays out on their behalf under the terms of undisclosed discounting arrangements with health care providers." Id.* at *2 (emphasis added). The court went on to note that the "fiduciary's covert profiteering at the expense of insureds is inconsistent with its duties of acting 'solely in the interest of the participants and beneficiaries.'" *Id.* at *7 (quoting 29 U.S.C. § 1104(a)(1)(A)).

Drawing parallels to the case under consideration, Herdrich sets forth, in the amended third count of her complaint, the intricacies of the defendants' incentive structure. *The Plan dictated that the very same HMO administrators*

vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/administrators' year-end bonuses were based on the difference between total plan costs (i.e., the costs of providing medical services) and revenues (i.e., payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.

For the purposes of a motion to dismiss, we are obligated to view complaints in the light most favorable to the non-moving party and assume all factual allegations to be true. *See Scheuer v. Rhodes*, 416 U.S. 232, 236, 94 S.Ct. 1683, 1686, 40 L.Ed.2d 90 (1974). Herdrich's amended count III alleged "a claim for relief" that the incentive scheme, which invited and encouraged plan fiduciaries to place their own interests ahead of the interests of plan beneficiaries, constituted a breach of the administrators' fiduciary duty, and that "[a]s a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses . . . ." If we accept her allegations of a breach and claim of damages as true, as we are required to do, she has established sufficient grounds to defeat the motion to dismiss.

The dissent disagrees with this aspect of today's holding, which it characterizes as concluding that "the mere existence of this asserted conflict [i.e., the conflict between the incentive scheme for Carle doctors to limit medical care and treatment, on

the one hand, and the fiduciary duty of Carle to the beneficiaries, on the other], without more, gives rise to a cause of action for breach of fiduciary duty under ERISA." That is not the conclusion we reach. Our decision does not stand for the proposition that the existence of incentives *automatically* gives rise to a breach of fiduciary duty. Rather, we hold that incentives *can* rise to the level of a breach where, as pleaded here, the fiduciary trust between plan participants and plan fiduciaries no longer exists (*i.e.*, where physicians delay providing necessary treatment to, withhold administering proper care to, plan beneficiaries for the sole purpose of increasing their bonuses).

The dissent admittedly does "not rule out the possibility that the imposition of incentives to limit care could support a claim of breach of fiduciary duty." In its view, such a claim might very well be viable when "there is a serious flaw in the manner in which the incentive arrangement is established. . . ." Having said this, we fail to see how it can conclude that Herdrich did not plead such a flaw in the structure of the incentive program at issue. Her amended count III included the following allegation:

> a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;
>
> b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

> i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:
>
> (1) minimize the use of diagnostic tests;
>
> (2) *minimize the use of facilities not owned by CARLE; and*
>
> (3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians.
>
> ii. by administering disputed and non-routine health insurance claims and determining:
>
> (1) *which claims are covered under the Plan and to what extent;*
>
> (2) *what the applicable standard of care is;*
>
> (3) *whether a course of treatment is experimental;*
>
> (4) *whether a course of treatment is reasonable and customary; and*
>
> (5) *whether a medical condition is an emergency.*

Thus, Herdrich alleges a "serious flaw" that springs from the authority of physician/owners of Carle *to simultaneously control the care of their patients and reap the profits generated by the HMO through the limited use of tests and referrals.* Under the terms of ERISA, Herdrich most certainly has raised

the specter that the self-dealing physician/owners in this appeal were not acting "solely in the interest of the participants" of the Plan.

The dissent also stresses that ERISA allows fiduciaries to adopt dual loyalties, and that maintaining dual loyalties does not in itself constitute a breach of fiduciary duty. We do not disagree with this contention, for it is well established that dual loyalties are tolerated under ERISA. *See, e.g., Donovan v. Bierwirth*, 538 F. Supp. 463, 468 (E.D.N.Y. 1981). Our point is not that a fiduciary may not have dual loyalties; it is that the tolerance of dual loyalties does not extend to the situation like the case before us where a fiduciary jettisons his responsibility to the physical well-being of beneficiaries in favor of "loyalty" to his own financial interests. Tolerance, in other words, has its limits.

In *Donovan*, the defendant, an executive of the Grumman Corporation, served as a trustee of the corporation's pension fund, and invested the fund's finances in Grumman stock. *See id.* at 465. The court ruled that although the defendant had dual loyalties when he acted as an officer of the fund-sponsoring corporation, his primary loyalty to the fund was the only loyalty that could affect his judgment. *See id.* at 468. The court found that ERISA authorizes "a trustee to invest in sponsor corporation stock in spite of dual loyalties and conflicting interests so long as (1) he acts exclusively for the benefit of the plan beneficiaries and participants and otherwise complies with ERISA section [1104], and (2) his actions are not violative of the proscriptions of ERISA section [1106]."[8] *Id.* at 469. A trustee with such dual loyalties has an obligation to act

[8] Section 1104(a)(1) of ERISA provides that a "fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries."

fairly and equitably on behalf of those concerned with the result of the action taken. *See Donovan*, 538 F. Supp. at 469 (citation omitted).

The dissent, presumably, would not agree with *Donovan's* effort to mark the border between an acceptable dual loyalty and the impermissible breach of fiduciary duty. From our reading, the dissent would not mark a border at all. It seems to argue that dual loyalties, and incentive schemes generally, are *per se* valid almost without limitation, and that only when there is a "breakdown in the market," or some "serious flaw" in the manner in which the incentive arrangement in question is established, can there possibly be a breach of fiduciary duty. Specifically, the dissent notes, without citation to any authority, that "plan sponsors are likely to take their business elsewhere if they perceive that incentives are working to the detriment of beneficiaries or the plan itself, and thus market forces go a long way towards ensuring that incentives do not rise to dangerous or undesirable levels."

To our way of thinking, the dissent's market theory flies in the face of the facts as set forth in the very record before us. On March 7, 1991, Pegram, Herdrich's doctor, discovered a six by eight centimeter "mass" (later determined to be her appendix) in Herdrich's abdomen. Although the mass was inflamed on March 7, Pegram delayed instituting an immediate treatment of Herdrich, and forced her to wait more than one week (eight days) to obtain the accepted diagnostic procedure (ultrasound) used to determine the nature, size and exact location of the mass. Ideally, Herdrich should have had the ultrasound administered with all speed after the inflamed mass was discovered in her abdomen in order that her condition

could be diagnosed and treated before deteriorating as it did,[9] but Carle's policy requires plan participants to receive medical care from Carle-staffed facilities in what they classify as "non-emergency" situations. Because Herdrich's treatment was considered to be "non-emergency," she was forced to wait the eight days before undergoing the ultrasound at a Carle facility in Urbana, Illinois. During this unnecessary waiting period, Herdrich's health problems were exacerbated and the situation rapidly turned into an "emergency"—her appendix ruptured, resulting in the onset of peritonitis. In an effort to defray the increased costs associated with the surgery required to drain and cleanse Herdrich's ruptured appendix, Carle insisted that she have the procedure performed at its own Urbana facility, necessitating that Herdrich travel more than fifty miles from her neighborhood hospital in Bloomington, Illinois. The "market forces" the dissent refers to hardly seem to have produced a positive result in this case—Herdrich suffered a life-threatening illness (peritonitis), which necessitated a longer hospital stay and more serious surgery at a greater cost to her and the Plan. And, as discussed below, we are far from alone in our belief that market forces are insufficient to cure the deleterious affects of managed care on the health care industry.

Across the country, health care critics and consumers are complaining that the quality of medical treatment in this nation is rapidly declining, leaving "a fear that the goal of managing care has been replaced by the goal of managing costs." Jan Greene, *Has Managed Care Lost Its Soul? Health*

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[9] Doctor Hyman Lans, Herdrich's medical expert, stated at his deposition that Herdrich's condition worsened during the eight-day waiting period "[b]ecause obviously there has been another week of the appendix becoming necrotic and sitting in the pus, and obviously the process has continued during that week and doesn't correct itself."

Maintenance Organizations Focus More on Finances, Less on Care, Am. Hosp. Publishing Inc., May 20, 1997.

> An increasing number of Americans believe that dollars are more important than people in the evolving [HMO] system. Whether justified or not, this assumption needs to be taken seriously, according to keepers of the industry's conscience. University of Pennsylvania bioethicist Arthur Caplan argues that managed care should take a lesson from professional sports, which has alienated some fans because money and profits have eclipsed the reasons why fans care about the games; hero worship and the virtues of teamwork, loyalty and trustworthiness. The same goes for doctors. "People go to their doctor not because he's a good businessman . . . but because he's a good advocate, someone we can admire," says Caplan. "If we have to struggle with him to get what we want, we will have no trust anymore."

To regain trust, HMOs need to be more sensitive to the doctor-patient relationship and remove the physician from direct financial interest in patient care, says Caplan. Instead, doctors should have a predetermined budget and be able to advocate for patients without direct personal gain or loss.

Another hot-button issue for HMO members is the fear that a lifesaving experimental procedure will be denied because of its cost. Caplan says the industry should follow the lead of the handful of HMOs that have established outside, independent panels to make final decisions.

Id. Even care providers fear that they "have become somewhat preoccupied with [their] ownership status and consequently have not paid as much attention as [they] should have to improving [their] basic core competencies." *Id.* The specter of money concerns driving the health care system, says a group of Massachusetts physicians and nurses, "threaten[s] to transform healing from a covenant into a business contract. Canons of commerce are displacing dictates of healing, trampling our professions' most sacred values. Market medicine treats patients as profit centers." *For Our Patients, Not for Profits: A Call to Action*, JAMA, Dec. 3, 1997, at 1773. As one professional stated, "It's too bad. We used to spend most of our time worrying about how to do a better job. Now we worry about doing a better job at a lower price." *Id.*

Thousands of American physicians and nurses, outraged by the increasingly "corporate" nature of American medicine, recently staged a reenactment of the Boston Tea Party by symbolically dumping $1 million each minute into Boston Harbor to dramatize the amount of health care money that is being wasted to pay for HMO marketing, profits, and administrative salaries. *See id.*

> The shift to profit-driven care is at a gallop. For nurses and physicians, the space for good work in a bad system rapidly narrows. For the public, who are mostly healthy and use little care, awareness of the degradation of medicine builds slowly; it is mainly those who are expensively ill who encounter the dark side of market-driven health care. We criticize market medicine not to obscure or excuse the failings of the past, but to warn that the changes afoot push nursing and medicine farther from caring, fairness, and efficiency.

Id. Another commentator observed that "American 'market theology' is being invoked as an excuse for the downgrading of patient care and the growing absence of compassion in health care." Bob LeBow, *Nation Needs to Take Control of Health Care System for Patients, not Profits,* Idaho Statesman, Dec. 2, 1997, at 6A. Instead of providing health care, doctors are forced to "spend many hours persuading health insurance companies that we are to trying to manipulate them into paying more money than Medicare does for kidney transplants." Gabriel M. Danovitch, et al., *And How the Decisions Are Made*, 331 New Eng. J. Med., at 331-32 (1984).

In order to minimize health care costs and fatten corporate profits for HMOs, primary care physicians face severe restrictions on referrals and diagnostic tests, and at the same time, must contend with ever-shrinking incomes.

> Sixty percent of all managed-care plans, including HMOs and preferred-provider organizations, now pay their primary-care doctors through some sort of "capitation" system, according to the Physician Payment Review Commission in Washington, D.C. That is, rather than simply pay any bill presented to them by your doctor, most HMOs pay their physicians a set amount every month—a fee for including you among their patients. At Chicago's GIA Primary Care Network, for instance, physicians get $8.43 each month for every male patient . . . and $10.09 for every female patient . . . . Some HMOs, such as Oxford Health Plans, Cigna and Aetna, have "withhold" systems, in which a percentage of the doctors' monthly fees are withheld and then reimbursed if they keep their

> referral rates low enough. Others, like U.S. Healthcare, pay bonuses for low referral rates.

John Protos, *Ten Things Your HMO Won't Tell You*, Inside, June 30, 1997, at 44.

> [T]here is ample evidence that the bottom line mentality is taking over. HMOs refer to the proportion of premiums they pay out for patient care as their "medical-loss ratio"—a chilling choice of words. The Association of American Medical Colleges reported last November that medical-loss ratios of for-profit HMOs paying a flat fee to doctors for treatment averaged only 70% of their premium revenue. The remaining 30% went for administrative expenses—and profit.

George J. Church, *Backlash Against HMOs*, Time, Apr. 14, 1997, at 32. Doctors, in accordance with bureaucracy-like HMO and government (*i.e.*, Medicare) reporting regulations, are often required to engage in countless hours of paper shuffling and file stacks of forms to complete even the most basic reimbursement claims. Moreover, the recent trends of sky-rocketing malpractice insurance rates has put additional stress on physicians and surgeons: certain specialists may spend 60 percent of their overhead costs on malpractice insurance, some obstetrician-gynecologists pay $100,000 per year for coverage, and neurosurgeons or orthopaedic surgeons can pay in excess of $100,000 per year. *See* Charles Krauthammer, *Driving the Best Doctors Away; Physicians are Getting Hammered by Managed Care Micromanagement and Malpractice Insurance Premiums*, Wash. Post, Jan. 9, 1998, at A21. In fact, many observers note that an increasing number of physicians are abandoning the profession because they are disenchanted with the notion of having "medically

ignorant administrators" dictate that they limit patient care so as to pad the pockets of the officers of insurance companies and HMO organizations. *See id.* "More than money, this is what is driving these senior doctors crazy: some 24-year-old HMO functionary who knows as much about medicine as he does about cartography demanding to know why Mr. Jones, the diabetic in renal failure, has not been discharged from the hospital yet." *Id.* Nor is the market serving the future of the practice of medicine well—the pool of applicants at our nation's medical schools seems to be drying up; many potential doctors cite increased costs and unpleasant, HMO-controlled working conditions as key factors driving the nation's aspiring surgeons away from the operating table. *See* Judith Graham, *Medical School Applicants Dip*, Chi. Trib., Feb. 1, 1998, at 1. Yet another consequence of the increase in HMO decision-making authority has been a dramatic rise in consumer disputes with HMOs. Last year, consumers in the State of Wisconsin filed nearly 5,000 grievances against Wisconsin HMOs, almost a third more than in 1986. Of these 5,000 grievances, HMOs reversed their care decisions in 68 percent of complaints. *News From Every State*, USA Today, June 4, 1998, at 10A.

Many physicians, frustrated with the cost pressures of managed care, including those attributable to unnecessary HMO, insurance company, and governmental regulations, have attempted to counter the influence of large, regional health care providers by organizing into unions. *See Doctors Seeking to Unionize: A Remedy?*, Chi. Trib., Feb. 1, 1998, at 10. Collective bargaining provides unionized doctors with the ability to wield greater leverage when faced with an HMO's efforts to reduce physicians' incomes. *See id.* Doctors who are dissatisfied with the corporate, profit-driven nature of HMOs, as well as the loss of independence in the doctor-patient relationship, are also considering competing head-on

and are forming their own HMOs, just as was done here. Many of these physicians and surgeons have joined their respective specialty practices and linked up with local hospitals to compete with regional HMOs for managed care contracts. But in these circumstances, as in our case, doctors often assume the dual role of care-provider and HMO administrator, and are ultimately held accountable for breaches of fiduciary duty.

This court has previously addressed the cost-saving pressures currently being exerted on medical-care providers. In *State of Wis., Dep't. of Health and Soc. Servs. v. Bowen*, 797 F.2d 391 (7th Cir. 1986), the author of this majority opinion addressed the Secretary of Health's control over Medicaid's patient care costs.

> A nursing practitioner or physician's assistant is not adequately trained to make the all-important decision dealing with levels of care. It is shocking in our day of advanced medical research, techniques and surgery, when organ transplants and space medicine research are routinely-accepted medical procedures, that we seem to be forgetting and casting aside the all-important human and personal element in medical care. It is equally shocking that we are in effect turning the medical transfer decisions over to the paper shuffling bureaucrat for a review of an inadequately trained medical support assistant. Nursing practitioners and physician's assistants are incapable of making this life-threatening judgment, because they lack both the personal contact with the patient and his family over a period of time, and most frequently lack the necessary expertise, training and experience in psychology, psychiatry and geriatrics

> required to properly interpret and knowledgeably assess the dangers of transfer trauma.

Id. at 410 (Coffey, J., dissenting).[10]

We must remember that doctors, not insurance executives, are qualified experts in determining what is the best course of treatment and therapy for their patients. Trained physicians, and them alone, should be allowed to make care-related decisions (with, of course, input from the patient). Medical care should not be subject to the whim of the new layer of insurance bureaucracy now dictating the most basic, as well as the important, medical policies and procedures from the boardroom. If it is, "the cost cutting of managed health organizations and insurers may undermine what is, for now, the best medical care in the world." Joan Beck, *"Drive-by Deliveries" Risky Health Game*, Hous. Chron., Oct. 28, 1995, at 36. It shall also place physicians in a more severe conundrum, forcing them to limit the costs associated with nature and duration of treatment while, at the same time, attempting to avoid the liability of a medical malpractice suit.

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[10] In *Bowen*, the United States Department of Health and Human Services sued the state of Wisconsin, alleging that the state's of administering Medicaid care was not in strict compliance with federal requirements. *See id.* at 392-93. As a result, the Department disallowed several reimbursements for the state's Medicaid expediture. *See id.* at 393. The state responded that the Wisconsin system saved money and was in the best interest of its citizens. *See id.* at 394. Although the majority opinion supported the Department of Health and Human Services, the state's petition for certiorari was granted. *See* 479 U.S. 1053, 107 S. Ct. 926, 93 L. Ed.2d 978 (1987). However, a few days prior to oral argument before the Supreme Court, the Department settled with the state, thereby avoiding further consideration of the issue.

A response to the crisis in market-based care has come to roost in Washington, D.C., as a result of constituent sentiment from across the country. Legislation has been introduced that would place restraints on HMOs, provide a "bill or rights"[11] to unhappy health care consumers, and even extend to HMO participants the power to individually sue their health plans for damages. *See* Laura Litvan, *Has Managed Care Hurt Quality?*, Investors Bus. Daily, May 1, 1998, at A1. This ability to sue may possibly serve in some measure to rectify the troubling state of affairs which currently exists, where patients can be without a remedy for medical malpractice. *See* Jamie Court, *Holding HMOs Accountable for their Egregious Conduct*, Chi. Trib., June 22, 1998, at 13 ("HMOs overturn doctors' decisions, deny treatment and then claim in court that they don't practice medicine, only provide coverage, so that HMOs cannot be sued for medical malpractice"). These proposals are still being debated in the committee hearing stage of the legislative process, and as yet have not been enacted to control the accelerated decline of our health care system.

Along the same lines as its "market forces" argument, the dissent submits that the defendants' plan "encourag[ed] physicians to use resources more efficiently." Although we agree, at least in principle, with the idea that financial incentives may very well bring about a more effective use of plan assets, we certainly are far from confident that it was at work in this

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[11] Indeed, many Americans view health care as a right: "Although the U.S. has currently opted for a market-based health care system, the public has shown by the recurrent eruptions of outrage that it views health care as a social good, and even a right, not a commodity." Greene, *supra* at p.375. While health care may not in fact be a right, the doctor's decision-making authority when administering treatment should not be cast asunder by an insurance company's mandate on physicians that monetary concerns be placed above the quality of care, especially in those case where the doctor is not even required to apprise the patient of more effective, but more expensive, options.

particular case. The Carle health plan at issue was not used as efficiently as it should have been. Indeed, the eight-day delay in medical care, and the onset of peritonitis Herdrich incurred as a result of such delay in diagnosis, subjected her to a life-threatening illness, a longer period of hospitalization and treatment, more extensive, invasive and dangerous surgery, increased hospitalization costs, and a greater ingestion of prescription drugs.

The dissent also somehow contends that "ERISA tolerates some conflict of interest on the part of fiduciaries," and therefore, "allowing a plan sponsor to designate its own agent as a fiduciary reassures the sponsor that, in devoting its assets to the plan, it has not relinquished all ability to ensure that the plan's resources are used wisely." In so doing, the dissent relies on two cases from this circuit, *Chalmers v. Quaker Oats Co.*, 61 F.3d 1340 (7th Cir. 1995), and *Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan*, 144 F.3d 1014 (7th Cir. 1998). In *Chalmers*, the plaintiff, Chalmers, a former officer of the defendant Quaker Oats Company, brought an ERISA action against the severance pay program of his former employer. *See* 61 F.3d at 1342. Chalmers challenged his denial of severance benefits, arguing that the program's severance committee's ruling should be reversed because its members, who were all officers of the Quaker Oats Company, operated under a conflict of interest. *See id.* at 1344. We held that an automatic bias did not exist against the distribution of severance benefits, in spite of the fact that the members of the severance benefit distribution committee were officers of the corporation. *See id.*

Similarly, in *Mers*, Dale Mers worked for the defendant Marriott International, Inc. and was a member of Marriott's accidental death and dismemberment insurance plan. *See* 144 F.3d at 1017-18. While participating in a company-sponsored

volunteer project, he suffered a heart attack, fell to the ground, and expired a short time thereafter. Mers' wife, Pamela, submitted a proof of claim under the plan. In order to have qualified to receive benefits under Marriott's plan, the decedent's "injury" had to have been caused by the "accident." *See id.* at 1018-19. The plan insurer, American International Group ("AIG"), was given dual authority to serve both as plan insurer and the decision-maker in determining which claims qualified for payment. AIG denied Pamela the benefits she was seeking because, among other reasons, "the definition of injury found in the policies and the disease exception in ... [the] policy did not cover Dale Mers' death" and, in its view, "an accident did not cause his death." *Id.* at 1018-19. Pamela filed a complaint asserting that Marriott wrongfully denied her claim, in violation of sections 502(a)(1)(B) and 1132(a)(1)(B) of ERISA. The district court, in granting the plan's motion for summary judgment, found that, although AIG's dual-role caused the insurer to operate under an inherent conflict of interest, the plan's denial of benefits was reasonable to the extent that Dale Mers' death was not an "injury" under the terms of the plan. *See id.* at 1019. We affirmed in *Mers*, but concluded that "no conflict of interest exists because paying meritorious claims is in AIG's best interest," that is, it would harm AIG in the long run to consistently deny valid claims "by inducing current customers to leave and by damaging its chances of acquiring new customers." *Id.* at 1020-21.

In considering our decisions in *Mers* and *Chalmers*, it is important to note that this court has heretofore not been called upon to address the situation where each and every member of the benefit plan's administrative review board were the very owners of the plan, and plan beneficiaries were without a single representative on the board. In our view, *Chalmers* and its ilk are distinguishable from the facts in this appeal because, whereas the members of the Quaker severance committee were

all officers of Quaker, not one of the officers was an "owner" of, or had a direct financial interest in, the Quaker Oats Company, as was the case here. According to the record before us, the doctors who owned Carle and provided medical care to plan beneficiaries were the very same individuals who served as officers and directors of HAMP, the plan-administrating subsidiary of Carle. As the plaintiff alleged in her complaint, it is more likely than not that an incentive existed for the Carle doctors to abuse the dual loyalties that they observed in administering the Plan by "minimiz[ing] the use of diagnostic tests[,] ... the use of facilities not owned by CARLE[,] ... and the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians."

The dissent implies that Herdrich's claim of breach should fail because, in *Chalmers*, we held that the severance benefits paid by Quaker officers, which were distributed from corporate earnings, did not give rise to a claim for breach of fiduciary duty. As this Court noted in *Chalmers*, "[Quaker] is a corporation which generates revenues of nearly $6 billion annually and is therefore not likely to flinch at paying out $240,000 [the amount in question in the *Chalmers* case]." 61 F.3d at 1344. The dissent attempts to liken the benefits distribution scheme in *Chalmers* to the one in this case by quoting the following language from *Chalmers*: "[I]t is also a poor business decision to make it a practice of resisting claims for benefits. In the long run, such a practice would dampen loyalties of current employees while hindering attempts to attract new talent." *Id.* Importantly, however, the officers in *Chalmers* who made the decision to distribute severance benefits were not the owners of the corporation. In fact, nothing in the facts of *Chalmers* leads us to infer that Quaker officers were shareholders, or even had an interest in the financial well-being of the company. Moreover, it is somewhat misleading to compare a $6 billion corporate entity like Quaker

with HAMP, which holds less than $14 million in assets.[12] A doctor who is responsible for the real-life financial demands of providing for his or her family—sending four children to school (whether it be college, high school or primary school), making house payments, covering office overhead, and paying malpractice insurance—might very well "flinch" at the prospect of obtaining a relatively substantial bonus for himself or herself. *Here, the Carle physicians were intimately involved with the financial well-being of the enterprise in that the yearly "kick-back" was paid to Carle physicians only if the annual expenditure made by physicians on benefits was less than total plan receipts. According to the complaint, Carle doctors stood to gain financially when they were able to limit treatments and referrals.* Due to the dual-loyalties at work, Carle doctors were faced with an incentive to limit costs so as to guarantee a greater kickback. In *Chalmers*, by comparison, the drain on profits resulting from a payout of benefits had no direct link at all to the officers' annual salaries.

In summary, we hold that the language of the plaintiff's complaint is sufficient in alleging that the defendants' incentive system depleted plan resources so as to benefit physicians who, coincidentally, administered the Plan, possibly to the detriment of their patients. The ultimate determination of whether the defendants violated their fiduciary obligations to act solely in the interest of the Plan participants and beneficiaries, *see* 29 U.S.C. § 1104(a)(1), must be left to the trial court. On the surface, it does not appear to use that it was in the interest of plan participants for the defendants to deplete the Plan's funds by way of year-end bonus payouts. Based on the record we have

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[12] While the record does not reflect exactly what HAMP's assets are, as of December 31, 1992, its largest affiliate and/or subsidiary corporation had assets totaling $13,847,000, which were admittedly more than HAMP's.

before us, we hold that the plaintiff has alleged sufficiently a breach of the defendants' fiduciary duty.

3. *Loss to Plan*

Finally, the defendants argue that Herdrich's claim must be dismissed because she does not allege that she suffered any loss attributable to the defendants' disputed breach. Specifically, they contend that beneficiaries in an ERISA plan may not recover anything other than the benefits provided expressly in the Plan itself. This is a mischaracterization of the law as it stands in this circuit.

ERISA allows any plan beneficiary to sue any plan fiduciary for beach of fiduciary duty. "Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by [ERISA] shall be personally liable to make good to such plan any losses to the plan resulting from each such breach . . . ." 29 U.S.C. § 1109(a). Furthermore:

> A civil action may be brought—
>
> (3) by a participant, beneficiary, of fiduciary (A) to enjoin any act or practice which violates any provision of [ERISA] or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of [ERISA] or the terms of the plan . . . .

Id. at § 1132(a). "There can be no disagreement . . . that § [1132(a)] authorizes a beneficiary to bring an action against a fiduciary who has violated § [1109]." *Massachusetts Mut. Life Ins. Co. v. Russell*, 473 U.S. 134, 140, 105 S.Ct. 3085, 3089, 87 L.Ed.2d 96 (1985). ERISA's "draftsmen were

primarily concerned with the possible misuse of plan assets, and with remedies that would protect the entire plan, rather than with the rights of an individual beneficiary." *Id.* 473 U.S. at 142, 105 S.Ct. at 3090 (footnote omitted). In such suits, plan beneficiaries have standing to bring an action on behalf of the plan itself to recoup monies expended in violation of ERISA, as the plaintiff has done here. *See* 29 U.S.C. § 1132(a). "[T]he fiduciary duties set forth in § [1109] run only to the plan, and not to individual beneficiaries." *Harsch v. Eisenberg*, 956 F.2d 651, 657 (7th Cir. 1992) (citation and internal quotation omitted). In paragraph 13 of her complaint, Herdrich alleges that as a result of the defendants' actions, the Plan was deprived of the supplemental medical expense payment amounts in controversy. We thus hold that she has alleged with sufficient clarity that the Plan suffered a loss as a result of the defendants' actions.

IV. CONCLUSION

We conclude that this court has jurisdiction to consider Herdrich's appeal and that the trial judge erred in dismissing the plaintiff's amended count III against the defendants for breach of fiduciary duty under ERISA. We reverse the district court's order dismissing the plaintiff's amended count III and remand for further proceedings consistent with this opinion.

REVERSED.

FLAUM, Circuit Judge, dissenting.

This is a case of first impression in which the plaintiff alleges that the imposition of financial incentives designed to limit the provision of health care benefits constitutes a breach of fiduciary duty under ERISA. The plaintiff's complaint alleges that there is a conflict of interest built into the compensation

structure of the health plan in question. I fully accept the Majority's conclusion that, taking the allegations of the complaint as true, "an incentive existed for [the defendants] to limit treatment and, in turn, HMO costs so as to ensure larger bonuses." Maj. Op. at 372. I disagree with the Majority's holding, however, that the mere existence of this asserted conflict, without more, gives rise to a cause of action for breach of fiduciary duty under ERISA. I respectfully dissent.

As described in the complaint, the defendants occupy two different roles in the health plan. The defendants are the plan's doctors, who provide medical care to the plan beneficiaries, and they are also the plan administrators, who (as fiduciaries) make decisions about what claims and conditions are covered under the plan. The complaint alleges that the defendants have breached their fiduciary duty in two ways. First, according to the complaint, the defendants have hired CARLE owner/ physicians (*i.e.*, themselves) to provide medical services under the plan while cutting costs by minimizing the resources expended on each patient. By minimizing these expenditures, the defendants preserve funds to be distributed to themselves as year-end bonuses. Second, the complaint alleges that the defendants have administered disputed and non-routine claims. Again, the implication is that these claims are administered with an eye towards denying these claims to augment the defendants' year-end bonuses. Thus, the complaint alleges a structural incentive to deny care both at the point of delivery (*i.e.*, the treatment decision affecting patient care) and at the point of entry (*i.e.*, the coverage decisions). In my view, however, merely pointing out the existence of these structural incentives does not suffice to make out a cause of action for breach of fiduciary duty under ERISA.

Consider first the defendants' alleged incentive to deny coverage in disputed and non-routine claims. Based on the

allegations in the complaint, there is indeed an incentive to deny claims and thereby maintain large year-end bonuses. Unlike the common law of trusts, however, which is merely the baseline for determining the scope of fiduciary duty under ERISA, *see Varity Corp. v. Howe,* 516 U.S. 489, 496-97, 116 S.Ct. 1065, 134 L.Ed.2d 130 (1996), ERISA tolerates some conflict of interest on the part of fiduciaries. Most notably, section 408(c)(3) of ERISA permits an employer or other plan sponsor to have its own "officer, employee, agent, or other representative" serve as trustee or other fiduciary. 29 U.S.C. § 1108(c)(3). *See Donovan v. Bierwirth,* 538 F.Supp. 463, 468 (E.D.N.Y.1981) (describing § 408(c)(3) as "an unorthodox departure from the common law rule against dual loyalties"). One justification for this departure from the common-law tradition is that allowing a plan sponsor to designate its own agent as a fiduciary reassures the sponsor that, in devoting its assets to the plan, it has not relinquished all ability to ensure that the plan's resources are used wisely. This reassurance in turn encourages more employers and other sponsors to establish benefits plans. *See* Daniel Fischel & John Langbein, *ERISA's Fundamental Contradiction: The Exclusive Benefit Rule,* 55 U. CHI. L.REV. 1105, 112728 (1988). Although the dual loyalty ascribed to the defendants in this case is not identical to the conflict experienced by a fiduciary who is also the sponsor's agent, section 408(c)(3) demonstrates that dual loyalties are not *per se* unlawful under ERISA.

Moreover, we have recognized in a related context that market forces help reduce the risk that the fiduciary's conflict of interest in making coverage decisions will work to the detriment of the plan and the plan beneficiaries. In reviewing denials of benefits under section 502(a)(1)(B) of ERISA, we are often confronted with situations in which the plan administrator had a financial incentive to deny claims. For instance, in *Chalmers v. Quaker Oats Company,* 61 F.3d 1340 (7th Cir.1995), the

plaintiff argued that corporate officers who served on the plan administration committee had an automatic bias against dispensing severance benefits because those benefits would be paid directly from the corporation's earnings. *Id.* at 1344. In rejecting the plaintiff's claim of bias, we explained that "it is a poor business decision to make it a practice of resisting claims for benefits. In the long run, such a practice would dampen loyalties of current employees while hindering attempts to attracts new talent." *Id.; see also Van Boxel v. Journal Co. Employees' Pension Trust,* 836 F.2d 1048, 1051 (7th Cir. 1987). We have recently expanded on this rationale in finding that no conflict of interest existed when an insurer serving as a plan administrator denied a claim that, if it had been approved, would have been paid out of the insurer's assets:

> [I]t is a poor business decision to resist paying meritorious claims for benefits. Companies ... that sponsor ERISA plans are customers who choose which group insurance policies they will use to fund their plans .... [T]hese employers want to see their employees' claims granted because they want their employees satisfied with their fringe benefits. These corporate employers have the sophistication and bargaining power necessary to take their business elsewhere if an insurer ... consistently denies valid claims. In the long run, this type of practice would harm an insurer by inducing current customers to leave and by damaging its chances of acquiring new customers. Thus, no conflict of interest exists because paying meritorious claims is in [the insurer's] best interest.

Mers v. Marriott Int'l Group Accidental Death & Dismemberment Plan, 144 F.3d 1014, 1020-21 (7th Cir. 1998).

The reasoning regarding conflicts of interest in the denial of benefits context applies with equal force to the plaintiff's claim of breach of fiduciary duty. The sponsor of the plaintiff's plan, State Farm, is a sophisticated, experienced player in the market for health benefits. The defendants do have a financial interest in denying coverage, just as the corporation did in *Chalmers* and the insurer did in *Mers*. But State Farm has an interest in ensuring that its employees are satisfied with their fringe benefits, and the defendants have an interest in ensuring that State Farm is satisfied with the defendants' performance in delivering health care to the beneficiaries. In this sense, the interests of the administrator align with the interests of beneficiaries and the sponsor. I recognize, of course, that monitoring of plan administrators by sponsors and beneficiaries is sometimes imperfect, and there is no guarantee that a sponsor will be able to find satisfactory alternatives in the marketplace. The plaintiff's complaint, however, alleges only that an incentive to deny coverage exists, which in my view is not enough to support an inference that market forces have failed in this case to protect the interests of beneficiaries.

The complaint's second allegation of breach of fiduciary duty, alleging an incentive to deny care at the point of delivery, also fails to state a claim upon which relief may be granted. As the Majority points out, such incentives are increasingly common in the age of managed care. Although the Majority identifies the potential pitfalls of managed care plans, *see* Maj. Op. at 374-77, there are also benefits to such plans that nevertheless make them attractive to many sponsors and beneficiaries of ERISA plans.[1] Since many sponsors and

[1] The goal of managed care plan is to deliver health care more cost-effectively by eliminating unnecessary or ineffective treatments and providing necessary care more efficiently. Some plans, like the one addressed in this case, attempt (continued...)

beneficiaries of managed care plans view financial incentives as a desirable way of conserving the plan's assets by encouraging physicians to use resources more efficiently, merely alleging the existence of financial incentives to limit care cannot suffice to make out a claim of breach of fiduciary duty.

The complaint could be ready to imply, however, that the defendants' incentives to limit care are so high that they work to the detriment of the plan and plan beneficiaries. When health plans provide physicians with incentives to internalize costs and maximize efficiency, as appears to be the case here,

[1] (...continued)
to achieve these goals by introducing incentives that encourage physicians to internalize part of the costs of treatment. (According to the complaint, the instant plan contains a bonus structure that makes the physician's income depend in part on how efficiently the physician delivers care by minimizing expenditure of resources.) Other plans try to achieve efficiency goals by implementing utilization review procedures, in which the treating physician must obtain from the insurer advance approval of patient-care decisions. This method also has its drawbacks, especially when the reviewer lacks the medical expertise of the treating physician. *See generally* E. Haavi Morreim, *Diverse and Perverse Incentives of Managed Care: Bringing Patients into Alignment*, 1 WIDENER L. SYMP. J. 89, 91-95 (1996) (describing the variety of cost-containment techniques employed by managed care plans).

Of course, the desirability of these different cost-containment measures from a policy standpoint is not our concern. But in assessing the plaintiff's assertion that incentives alone constitute a breach of fiduciary duty, it is worth noting that some commentators defend the use of financial incentives as a superior alternative to utilization review by insurers. By removing the insurer as an intermediary in patient care decisions, financial incentives can give physicians greater clinical autonomy (provided that the incentives are set at an appropriate level) and may lead to better decisions about how to reduce costs while maintaining quality. *See* Frances H. Miller, *Capitation & Physician Autonomy: Master of the Universe or Just Another Prisoner's Dilemma?*6 HEALTH MATRIX 89, 97-99 (1996); David Orentlicher, *Paying Physicians More to Do Less: Financial Incentives to Limit Care*, 30 U. RICH. L.REV. 155, 173-77 (1996).

there is a serious concern that patient care will suffer if the incentives to limit care are set too high. The task of identifying appropriate limits for incentives is an important item on the legislative and regulatory agenda. *See, e.g.*, 42 U.S.C. § 1395mm(i)(8) (regulating the use of financial incentives by health care plans treating Medicare and Medicaid recipients); 42 C.F.R. § 417.479 (same); Edward B. Hirshfeld, *Provider Sponsored Organizations and Provider Service Networks—Rationale and Regulation*, 22 AM. J.L. & MED. 263 (1996) (discussing avenues for regulating provider sponsored organizations, or PSOs, which are physician groups that bear investment and insurance risk with respect to the delivery of health care services). If the complaint is indeed asserting that the incentives in this case are excessive, then the plaintiffs in effect are inviting the court to make its own determination about appropriate incentive levels in managed care.

In reversing the dismissal of the plaintiff's complaint, the Majority appears to accept the invitation. In my view, however, judicial efforts to determine permissible levels of financial incentives through the vehicle of ERISA's fiduciary rules are unnecessary and ill-advised. No standards for conducting such an inquiry exist. Such a move would preempt legislative and regulatory efforts in this area and could seriously disrupt the ability of plan sponsors and beneficiaries to manage plan assets by agreeing to incentives that encourage cost-conscious medical decisionmaking. The Majority's decision provides little guidance for the district court on remand, and I fear that the decision today could lead, both in this case and in the future, to untethered judicial assessments of permissible incentive levels in health care plans.

Although I cannot join the Majority's decision in this case, I share the Majority's concern about the possibility of incentives that may harm plan beneficiaries, and I believe that

courts have a role in ensuring that incentives are implemented in accordance with the fiduciary duties imposed by ERISA. In my judgment, this role is triggered when the market fails to ensure that the interests of sponsors, administrators, and beneficiaries are in alignment. As noted above, plan sponsors are likely to take their business elsewhere if they perceive that incentives are working to the detriment of beneficiaries or the plan itself, and thus market forces go a long way towards ensuring that incentives do not rise to dangerous or undesirable levels. In order for the market to function in this context, however, sponsors and beneficiaries need information about the financial incentives that are in place. Thus, I would follow the Eighth Circuit's lead in holding that the failure to disclose financial incentives is a breach of fiduciary duty under ERISA. *See Shea v. Esensten*, 107 F.3d 625 (8th Cir. 1997), *cert. denied*,— U.S.—, 118 S.Ct. 297, 139 L.Ed.2d 229 (1997).[2]

Until the Majority's expansion of liability in today case, *Shea* stood at the frontier in terms of imposing liability under ERISA on health plans that seek to control costs by providing financial incentives to limit patient care. The *Shea* decision has

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[2] The Majority relies on *Shea* and another decision, *Ries v. Humana Health Plan, Inc.*, No. 94 C 6180, 1995 WL 669583 (N.D.Ill. Nov. 8, 1995), in reversing the dismissal of the plaintiff's complaint. *See* Maj. Op. at 372-73. I do not believe that these cases aid the plaintiff. In both cases, there was a breach of fiduciary duty because the health plan failed to disclose to plan beneficiaries the existence of financial arrangements between the plan and health care providers that allegedly operated to the detriment of the beneficiaries. *See Shea*, 107 F.3d at 628; *Ries*, 1995 WL 669583 at *2, *7. The complaint in the instant case, however, never asserts that the plaintiff's health plan failed to disclose the financial incentives under which its physicians were operating. Thus, these disclosure cases are inapposite to the plaintiff's theory, which appears to be that the mere existence of such incentives (or, at least, incentives that a court might feel are excessive) constitutes a breach of fiduciary duty.

proven to be controversial. *See, e.g., Weiss v. CIGNA Healthcare, Inc.*, 972 F. Supp. 748, 754-55 (S.D.N.Y.1997) (rejecting *Shea* and holding that there is no fiduciary duty under ERISA to disclose financial incentives to limit care); *see also* "Full Disclosure," ERISA LITIGATION REPORTER, April 1997 at 3 (describing *Shea* as "a decision that has been getting a lot of notice" and as a "far-reaching example" of "the expansion of disclosure duties into non-benefits contexts"). The Second Circuit has obliquely adopted *Shea's* rationale, however, in a decision upholding the denial of a motion for preliminary injunction. *See Maltz v. Aetna Health Plans*, 114 F.3d 9, 11-12 (2d Cir.1997). The health plan at issue in *Maltz* had been paying its participating physicians on a fee-for-service basis. When the health plan decided to switch to a capitation method of payment—which created a financial incentive to limit care by paying the physician a flat monthly fee for each enrollee on his or her list—the plaintiff-beneficiary sued for a breach of fiduciary duty under ERISA. The Second Circuit held that the plaintiff failed to demonstrate irreparable harm or a likelihood of success on the merits:

> [We] certainly acknowledge that incentive programs may affect the decisions physicians make in the treatment of their patients. Nothing in the contract between Aetna and its enrollees, however, limits Aetna's ability to make significant changes in its relationship with its doctors as long as the enrollees are aware of the changes when they renew their contract with Aetna and Aetna provides them with competent, alternative physicians . . . . Maltz renewed her contract with Aetna with full knowledge of these significant changes.

Id. at 12. Although the posture of *Maltz* as a preliminary injunction case makes it difficult to discern how the court would

ultimately rule on the merits, the *Maltz* opinion suggests at least a tentative acceptance of *Shea's* holding that nondisclosure of financial incentives to limit care may constitute a breach of fiduciary duty under ERISA.

Even when disclosures have been made, I would not rule out the possibility that the imposition of incentives to limit care could support a claim of breach of fiduciary duty when there is a serious flaw in the manner in which the incentive arrangement is established or a significant limitation on the ability of plan sponsors to obtain alternative arrangements in the market. Such a claim would have to make some allegation, which the plaintiffs in the instant case do not, pointing to special circumstances suggesting a breakdown in the market or in the negotiating process that led to the imposition of incentives. The complaint in this case, however, contains no allegation of nondisclosure, and it fails to make any allegations suggesting that the financial incentives to limit care are anything but the result of the bargain fairly struck between the plan's sponsor, administrator, and beneficiaries. I would affirm the decision below dismissing the complaint.

APPENDIX B

In the
United States Court of Appeals
For the Seventh Circuit

No. 97-10170

Cynthia Herdrich,

Plaintiff-Appellant,

v.

Lori Pegram, M.D., Carle Clinic Association,
and Health Alliance Medical Plans, Incorporated,

Defendants-Appellees.

On Petition for Rehearing and
Suggestion for Rehearing En Banc.

Decided March 8, 1999

Before Posner, Chief Judge, and Cummings, Harlington Wood, Jr., Coffey, Flaum, Easterbrook, Ripple, Manion, Kanne, Rovner, Diane P. Wood and Evans, Circuit Judges.

The case is before the court on a petition for rehearing and suggestion for rehearing en banc filed by the defendants-

appellees. On consideration of the petition for rehearing and suggestion for rehearing en banc, a vote of the active members of the court was requested. A majority did not favor rehearing en banc. Chief Judge Posner and Circuit Judges Flaum, Easterbrook and Diane P. Wood voted to grant rehearing en banc. A majority of the judges on the original panel voted to deny rehearing en banc.

Accordingly, IT IS ORDERED that the aforesaid petition for rehearing be, and the same is hereby, DENIED.

Easterbrook, Circuit Judge, with whom Posner, Chief Judge, and Flaum and Diane P. Wood, Circuit Judges, join, dissenting from the denial of rehearing en banc.

Physicians employed by Carle Clinic Association, a health maintenance organization (HMO), failed to diagnose Cynthia Herdrich's appendicitis before her appendix ruptured. Peritonitis ensued, and Herdrich has recovered $35,000 in damages for medical malpractice. She wants more, contending that Carle is a "fiduciary" under ERISA because her husband's employer State Farm Insurance Companies provided Carle's plan as a fringe benefit (making it a "welfare benefit plan" under ERISA), and that the divided loyalties at the core of an HMO structure are forbidden by ERISA. Like other HMO systems, Carle collects in advance for a period of care. The less medical services cost, the more an HMO's owners (here, Carle's physicians) have left as profit at the end of the period. According to the panel, this violates 29 U.S.C. § 1104(a)(1)(A).

Like any business, Carle seeks to hold down its costs. Like most other HMOs, Carle does this through devices that have come to be called "managed care." For example, subscribers must receive their medical care from Carle's own physicians if that is at all possible. Herdrich contends that this

rule is responsible for her peritonitis: after finding an inflamed mass in her abdomen, a Carle physician scheduled her for an ultrasound examination eights days later at a Carle facility in Urbana, Illinois, rather than arranging for a local hospital in Bloomington to perform that examination immediately. That delay, the jury found in the malpractice case, led to the peritonitis.

When participants in an HMO plan sought to apply the "fraud" label to the money-saving incentive that characterizes the HMO form of organization, we replied that the details of HMO incentives need not be specifically explained to participants in ERISA plans. *Anderson v. Humana, Inc.*, 24 F.3d 889 (7th Cir. 1994). The HMO structure differs substantially from traditional fee-for-service medicine in giving the HMO an incentive to skimp on care once an illness is discovered. It is equally true that the HMO system creates an inducement to keep the subscribers healthy as long as possible. An HMO makes its profit from healthy subscribers and thus provides ample preventive and diagnostic care, while many fee-for-service physicians make their living from sick or injured persons. If the HMO creates an incentive to provide too little care once a subscriber becomes seriously ill, the fee-for-service system coupled with insurance provides an incentive to furnish excessive care, for third parties foot the bill. A choice between prepaid and fee-for-service systems is accordingly difficult to make in principle.

What I find troubling about the panel opinion, and why I believe this case should be reheard en banc, is that the panel has condemned HMO and managed-care systems on medical grounds, 154 F.3d 362, 373-79 (7th Cir. 1998), and used its view of good medical practice as the basis of a conclusion that the HMO structure violates ERISA. According to the panel, market forces do not constrain the pernicious incentives that

HMOs adopt, and it is accordingly necessary to throw the weight of the law behind traditional fee-for-service medicine. *Id.* at 374-75 ("market forces are insufficient to cure the deleterious affects [sic] of managed care on the health care industry"). This aspect of the panel's approach is almost a 180° turn from what we wrote in *Anderson*, a case the panel did not cite:

> A health maintenance organization (HMO) offers, for a fixed fee, as much medical care as the patient needs. Providers using traditional fee-for-service methods, by contrast, charge for each procedure. Each method creates an unfortunate incentive: a physician receiving a fee for each service has an incentive to run up the bill by furnishing unnecessary care, and an HMO has an incentive to skimp on care (once patients have signed up and paid) in order to save costs. Each incentive encounters countervailing forces: patients, or insurers on their behalf, resist paying the bills for unnecessary services, and HMOs must afford adequate care if they are to attract patients. HMOs also have a reason to deliver excellent preventive medicine. Prevention may reduce the need for costly services later. Competition among the many providers of health care, and between the principal methods of charging for that care, affords additional protection to consumers.

24 F.3d at 890. But let this pass, and suppose that HMOs and other managed-care systems are inferior to available alternatives. Why does ERISA authorize a court to prescribe its view of the best system?

The answer, according to the panel, is that ERISA requires plan administrators to act as fiduciaries, while the HMO structure puts physicians at (financial) odds with their patients. HMOs are of course not unique in this regard; insurers likewise seek to minimize their outlays for medical care and employ managed-care devices to promote thrift. But I am willing to suppose that Carle did not act as Herdrich's "fiduciary" would have. It did not have to.

Under ERISA,

> a person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets, (ii) he renders investment advice for a fee or other compensation, direct or indirect, with respect to any moneys or other property of such plan, or has any authority or responsibility to do so, or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A) (emphasis added). Carle does not manage the State Farm plan or control its assets, so the panel emphasized sub-(iii), concluding that Carle has "discretionary authority or discretionary responsibility in the administration of such plan." *See* 154 F.3d at 369-71. Discretionary authority is obvious; but does Carle exercise discretion "in the administration of [the] plan", or only in the provision of medical services? This is a fundamental divide, for fiduciary status under ERISA is not an all-or-none affair. A person is a fiduciary only "to the extent" that he does one of the listed things; many major exercises of discretion, such as selecting the plan's terms, are outside of ERISA's fiduciary duties, even

though the same person is a fiduciary when implementing the plan. *See Hughes Aircraft Co. v. Jacobson*, 199 S. Ct. 755 (1999); *Lockheed Corp. v. Spink*, 517 U.S. 882 (1996); *McNab v. General Motors Corp.*, 162 F.3d 959 (7th Cir. 1998); *Johnson v. Georgia-Pacific Corp.*, 19 F.3d 1184, 1188 (7th Cir. 1994). A surgeon exercises a great deal of discretion when deciding how (if at all) to perform an operation, but the fact that an ERISA welfare benefit plan pays for the medical procedure does not make the surgeon a "fiduciary" of the patient and convert all medical-malpractice claims to federal common law under ERISA in the process. What is true at the level of a medical professional is true at the level of a medical practice group such as Carle. Unless the group exercises, not discretion in the abstract, but discretion "in the administration of [the] plan", it is not a fiduciary under ERISA. Lori Pegram, a physician employed by Carle, scheduled Herdrich for an ultrasound examination in Urbana on one day rather than in Bloomington on another; that does not sound like an exercise of discretion "in the administration of [the] plan". Similarly Carle's decision to establish one set of cost-saving incentives rather than another is not an exercise of discretion "in the administration of [the] plan"; it is an exercise of managerial discretion in the administration of Carle's business.

Perhaps it would be possible to read "in the administration of [the] plan" broadly in order to catch all discretionary elements of the HMO structure, but why should courts do this? In order to wipe out HMOs and foreclose the possibility that plan sponsors will choose that structure (or that participants will select it from among options the plan offers)? The panel's opinion sounds very much like this is the objective: its lengthy condemnation of managed care, 154 F.3d at 373-79, otherwise is hard to understand. But ERISA does not tie the plan sponsor's hands on issues of plan design. An employer is free to offer an HMO as an option without objection on

fiduciary-duty grounds. *Hughes* and *Lockheed*, which put plan-design issues outside the scope of § 1002(21), establish this point. If it is lawful under ERISA for an employer to offer an HMO as a welfare benefit, then it must be lawful for the HMO itself to administer a managed-care system. *Boyle v. United Technologies Corp.*, 487 U.S. 500, 506-07 (1988), observed that collecting damages from manufacturers of military hardware would, as a practical matter, limit the military's design choices. Just so with ERISA: a plan sponsor's right to adopt an HMO plan as a benefit would not be worth anything if implementing the HMO itself violates ERISA. What the panel has held comes to the same thing—though by a different route—as saying that welfare-benefit plans have a fiduciary duty not to adopt HMO or other managed-care options. If alternatives such as fee-for-service medicine are more expensive, then plan sponsors will be inclined to offer less medical coverage, and participants may be worse off. Clearly the panel thinks that they will be better off, and perhaps they will be. But ERISA allows plan sponsors and participants to choose for themselves. An employer is entitled to offer the combination of fringe benefits that it is willing to pay for; it need not offer the best available medical (or other) services. By stretching the definition of a "fiduciary" under ERISA, the panel has effectively foreclosed a popular option for the delivery of medical care and taken the decision out of private hands, to which ERISA committed it.

If Carle described to State Farm the cost-reduction incentives used by its plan, and State Farm knowingly chose Carle over other providers, then we have a simple plan-design issue. It would defeat the employer's right to specify the benefits conferred by a plan if the dissatisfied employee could turn around and sue the person who delivered those benefits. The only proper question in a suit against a supplier is whether that person did what he promised. Nothing in the panel's

opinion suggests that Carle Clinic pulled a fast one on State Farm. Fiduciary duties are vital when contracts are incomplete, but when a contract fully specifies proper behavior, then even a full-fledged trustee need not (indeed, must not) depart from the contractual provisions that the settlor established. *See* John H. Langbein, *The Contractarian Basis of the Law of Trusts*, 105 Yale L.J. 625, 657-69 (1995). Carle followed its contract with State Farm and with its subscribers; that is all ERISA requires.

Note the parallel to the fiduciary standard of diversification, to which the panel refers. 154 F.3d at 371-72. Managers of a plan's assets usually have a fiduciary duty to diversify their investments. Yet if the plan sponsor chooses a nondiversified strategy (for example, an employee stock ownership plan), then the trustee administering the ESOP need not diversify; one can't use a fiduciary duty to compel the trustee to disregard a decision consciously made by the sponsor. Even in the private law of trusts a fiduciary may implement the settlor's plan, despite features of that plan that a fiduciary could not adopt on its own (that is, without the settlor's consent). So if Carle is analogous to the trustee, then the settlor's (State Farm's) consent authorizes it to carry out the plan that the settlor approved.

Perhaps this issue boils down to a matter of characterization. If one conceives of particular medical services as the "benefits" under the plan, then Carle serves as the gatekeeper to those benefits, and handling claims for medical benefits defined by a plan is a fiduciary role under ERISA. *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134 (1985). But if instead one conceives of the CarleCare HMO system as the benefit promised by the ERISA plan, then Carle is not a "fiduciary." It is just the supplier of medical care, like the surgeon discussed above. Which characterization is

best? Herdrich does not allege that State Farm hired Carle to administer a medical plan that offers defined medical procedures as benefits; she alleges, rather, that the benefit State Farm offered is the CarleCare HMO system. And, for reasons I have already discussed, to the extent there is uncertainty about the right way to characterize Carle's role, the court should prefer the characterization that preserves plan sponsors' (and participants') freedom of choice. That means treating the Carle HMO as the benefit, rather than treating Carle as the administrator of the ERISA plan. If the HMO system is the benefit, then Carle is not acting as a fiduciary.

The choice between these characterizations is important —more than enough to justify convening the full court. Most medical care these days is furnished under ERISA plans. Most contemporary welfare benefit plans provide for managed care, through HMOs or other devices, at least as an option. The panel's opinion thus implies that the principal organizational forms through which medical care is delivered today are unlawful. If this conclusion is correct, then the cost-saving achieved by managed care must be abandoned, and the cost of medical care will rise, perhaps substantially.

I recognize that my colleagues in the majority of the panel have expressed their holding as a conclusion about this specific complaint and have written that cost-reduction incentives are not necessarily automatic violations of fiduciary duty. 154 F.3d at 373. But a holding such as this is impossible to cabin, for the plan attacked in this case is an ordinary HMO.

> Drawing parallels to the case under consideration, Herdrich sets forth, in the amended third count of her complaint, the intricacies of the defendants' incentive structure. The Plan dictated that the very same HMO

> administrators vested with the authority to determine whether health care claims would be paid, and the type, nature, and duration of care to be given, were those physicians who became eligible to receive year-end bonuses as a result of cost-savings. Because the physician/ administrators' year-end bonuses were based on the difference between total plan costs *(i.e.*, the costs of providing medical services) and revenues (*i.e.*, payments by plan beneficiaries), an incentive existed for them to limit treatment and, in turn, HMO costs so as to ensure larger bonuses. With a jaundiced eye focused firmly on year-end bonuses, it is not unrealistic to assume that the doctors rendering care under the Plan were swayed to be most frugal when exercising their discretionary authority to the detriment of their membership.

154 F.3d at 372 (emphasis in original). If Carle's setup violates ERISA, then all managed care does so, because the allegations in the complaint narrate mundane features of health maintenance organizations. Limiting care to specific locations, limiting referrals to specialists, and using capitation fees (with the possibility of profit from cost-reducing strategies), and reaping for the HMO's owners the benefits of reduced health-care expenditures, are the principal features of HMOs and "preferred provider organizations." Unlike some other HMOs, Carle is owned by its physicians, but I do not think that this makes a legal (or practical) difference. Physicians own much of the stock of HMOs organized as corporations or receive some of its profits as bonuses or salary increments; and no matter the HMO's internal organization, the benefit to a particular physician from a particular treatment decision is minuscule. The effect of holding down costs can be large in the aggregate, but

this is so whether the HMO is organized as a corporation or as a partnership. Indeed, it is so whether the organization is an HMO or a law firm. Lawyers owe fiduciary duties to their clients. Can it be that the incentive given by the partnership's reward structure to substitute the services of associates for those of the partners creates a conflict of interest that invariably violates those duties? If the answer is "no" for law firms (and that must be the right answer), it is "no" for HMOs, in stock or partnership form.

Even if all of this is wrong, however, the panel's opinion puts all managed-care systems at risk and commits the court to a long (and I should think unhappy) course of distinguishing "good" managed-care systems from "bad" ones. Assessments of this kind belong to plan sponsors and participants, not to judges. Federal law both recognizes and regulates HMOs. *See* 42 U.S.C. § 300(e). It seems to me unwise and improper for a court to use ERISA to impress a different view of desirable medical care on employers and HMOs alike.

APPENDIX C

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS

CYNTHIA HERDRICH,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 94-1143
	)	
LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, and HEALTH ALLIANCE MEDICAL PLANS, INC.,	)	
	)	
Defendants.	)	

ORDER

Before this Court is the Defendants' Motion to Dismiss [#34]. This matter was referred to the Magistrate Judge under Local Rule 1.4. On March 26, 1996, Magistrate Judge Robert J. Kauffman entered a Report & Recommendation granting the Motion. Pursuant to 28 U.S.C. § 636(b)(1), the parties had ten (10) working days after service of the Recommendation, until April 12, 1996, to file objections to the Magistrate's decision. Plaintiff, Cynthia Herdrich, filed a timely Objection to the Magistrate Judge's Report and Recommendation. On April 11, 1996, Defendants filed a Response to Herdrich's Objections.

After reviewing all relevant pleadings, this Court DENIES Herdrich's Objections to the Magistrate Judge's Report & Recommendation and ADOPTS the Report &

Recommendation in all respects. The Motion to Dismiss [#34] is allowed. Herdrich has twenty-one (21) days from the entry of this Order to replead her Count III ERISA claim. This matter is referred to Magistrate Judge Robert J. Kauffman for further proceedings.

Entered this 15th day of April, 1996.

/s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

APPENDIX D

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS
AT PEORIA

CYNTHIA HERDRICH Plaintiff	)	
vs.	)	Case No. 94-1143
LORI PEGRAM, et al. Defendant	)	

REPORT & RECOMMENDATION

This is an action removed from state court on a federal question. Now before the court is the defendants' Motion to Dismiss Amended Count 3 (#34). The motion is fully briefed, and pursuant to Local Rule 1.4 the district judge has referred the matter to me for a report and recommendation. After carefully considering all of the submissions of the parties, and pursuant to 28 U.S.C. § 636(b)(1)(B), I recommend that the motion be allowed and the plaintiff be given one last chance to re-plead an ERISA claim.

The plaintiff originally filed a complaint in state court claiming medical negligence on the parts of defendants Pegram and Carle Clinic Association (Carle). She later amended her complaint to add two counts of fraud pursuant to state law against defendants Carle and Health Alliance Medical Plans, Inc. (HAMP). The defendants removed the entire case to federal court, asserting that the two new counts were preempted by ERISA (Employees Retirement Income Security Act of 1974,

29 U.S.C. § 1101, *et seq.*). The plaintiff moved to remand the case, arguing that ERISA did not apply to Counts 3 and 4. Chief Judge Mihm denied that motion in an order dated August 5, 1994. (#13).

Thereafter the defendants Carle and HAMP moved for summary judgment on Counts 3 and 4, arguing that they did not state a claim under ERISA. Chief Judge Mihm allowed the motion as to Count 4 and denied it as to Count 3, but ordered the plaintiff to re-plead Count 3 under ERISA. (#29).

On September 1, 1995 the plaintiff filed an Amended Count 3, naming as defendants Carle, HAMP and Carle Health Insurance Management Co., Inc. (CHIMCO) (#31). It is this amendment that the defendants now move to dismiss.

A complaint should not be dismissed unless it appears from the pleadings that the plaintiff could prove no set of facts in support of her claim which would entitle her to relief. *Conley v. Gibson*, 355 U.S. 41 (1957). For purposes of a motion to dismiss, the complaint is construed in the light most favorable to the plaintiff and its factual allegations are taken as true. *Scheuer v. Rhodes*, 416 U.S. 232 (1974). In addition, a complaint must contain either direct or inferential allegations respecting all the material elements necessary to sustain a recovery under some viable legal theory. *Sutliff, Inc. v. Donovan Cos.*, 727 F.2d 648 (7th.Cir. 1984).

Amended Count 3 alleges that defendants Carle, HAMP, and CHIMCO have breached a fiduciary duty to the employee benefit plan under ERISA. The defendants move to dismiss arguing that Count 3 fails to state a claim under ERISA, and that the new claim is totally unrelated to the original claim for medical negligence.

Plan beneficiaries may sue any plan fiduciary for breach of fiduciary duty under ERISA, 29 U.S.C. § 1109(a). The complaint must allege facts identifying the defendants as fiduciaries and identifying the specific actions alleged to have breached the fiduciary duty. Merely repeating the statutory language will not state a claim, *Tybout v. Karr Barth Pension Admin., Inc.*, 819 F.Supp. 371 (D.Del. 1993). There is no ERISA action against a non-fiduciary, *Buckley Dement, Inc. v. Travelers*, 39 F.3d 784 (7th.Cir. 1994). Any relief awarded flows to the plan. There is no monetary relief available to an individual plaintiff, *Massachusetts Mutual Life Ins v. Russell*, 105 S.Ct. 3085 (1985).

In the case at bar, amended Count 3 fails to state a claim under ERISA for breach of fiduciary duty. First, none of the defendants is even mentioned in the Subscription Agreement attached to the complaint. The plaintiff fails to identify how any of the defendants is involved as a fiduciary to the Plan. For example, it is very difficult to see how Carle Clinic could be a fiduciary. Amended Count 3 merely repeats the statutory language of § 1109(a) with regard to fiduciaries.

The plaintiff should be allowed one last opportunity to re-plead under ERISA.

Even if the plaintiff could plead breach of fiduciary duty under ERISA, the court is concerned that the ERISA claim (which is the only basis for federal jurisdiction) is completely different from the original claim for medical negligence. In attempting to plead under ERISA, the plaintiff appears to be attacking the basic structure of the HMO and its arrangements with the Carle Clinic physicians. The alleged breach of fiduciary duty appears to involve how Carle physicians are paid by the HMO. The remedy for breach of fiduciary duty is reimbursement to the *Plan*. It is difficult to see how this alleged

breach arises out of the same transaction or occurrence as the medical negligence, which is necessary for the court's assertion of jurisdiction over the non-federal malpractice claim. In addition, the discovery and proof required for the ERISA claim is new and totally different from the discovery and proof on the malpractice claim. If an ERISA claim can be pleaded, it may be appropriate to sever and remand the malpractice action.

Accordingly, I recommend that the Motion to Dismiss Amended Count 3 (#34) be ALLOWED and that the plaintiff be given one last chance to re-plead the ERISA claim within 10 days of the date of final disposition of this motion by the court. Failure to re-plead will result in remand of the state claims.

The parties are advised that any objection to this recommendation must be filed in writing with the clerk of this court within ten (10) working days after service of this recommendation. *See*, 28 U.S.C. § 636(b)(1). Failure to object will constitute a waiver of objections on appeal. *Video Views Inc. v. Studio 21, Ltd.*, 797 F.2d 538 (7th Cir. 1986); F.R.Civ.P. 72.

ENTER this 26th day of March, 1996.

/s/ Robert J. Kauffman
ROBERT J. KAUFFMAN
UNITED STATES MAGISTRATE JUDGE

APPENDIX E

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS

CYNTHIA HERDRICH,	)	
	)	
Plaintiff,	)	
	)	
v.	)	Case No. 94-1143
	)	
LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, and HEALTH ALLIANCE MEDICAL PLANS, INC.,	)	
	)	
Defendants.	)	

ORDER

Before the Court are Defendants' Motion for Summary Judgment [#16] and Plaintiff's Motion for Leave to File Amended Complaint [#22]. For the reasons set forth herein, the Motion for Summary Judgment is GRANTED in part and DENIED in part. The Motion for Leave to File Amended Complaint is GRANTED in part and DENIED in part.

Factual Background

Plaintiff filed a two count complaint in State court on October 21, 1992. Count I alleged medical negligence against Defendant Lori Pegram ("Pegram") for failing to adequately examine, treat, and follow-up on Plaintiff's complaint of right,

lower quadrant pain. She claims that Pegram's failure to employ the skill and care ordinarily used by a reasonably well-qualified physician resulted in a ruptured appendix, which caused peritonitis. Count II seeks to hold Carle Clinic Association ("Carle Clinic") liable under the theory of respondeat superior. Defendants Pegram and Carle Clinic filed an Answer to the State court complaint on December 8, 1992.

Herdrich filed an addendum to her State court complaint in February 1994, adding Counts III and IV. Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance Medical Plans ("Health Alliance") in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq*. Count IV charges Health Alliance breached its duty of good faith and fair dealing. All of the Defendants filed a Notice of Removal with this Court on March 14, 1994, asserting that Counts III and IV were preempted by the Employees Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1101, and that the pendant state claims set forth in Counts I and II were removable pursuant to 28 U.S.C. § 1367. Herdrich filed a Motion to Remand on April 8, 1994.

Her Motion to Remand argued that ERISA did not preempt Counts III and IV of her State court complaint because the State laws at issue did not relate to an employee benefit plan. Plaintiff asserted that Counts III and IV were merely related to employee benefits generally. ERISA's preemption provision provides, in relevant part,

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State law insofar as they may now or

> hereafter relate to any employee benefit plan described in section 1003(a) of this title . . .

29 U.S.C. § 1144(a). She maintained that State law actions which are merely incidentally connected to an employee welfare benefit plan are not preempted by ERISA, citing *Mackey v. Lanier Collections Agency & Service*, 486 U.S. 825, 108 S.Ct. 2182 (1988). She concluded that Counts III and IV of her Complaint only indirectly affected the administration of a plan, in that her claims arose out Defendants business decisions and therefore were not preempted.

In opposition to the Motion to Remand, Defendants argued that Counts III and IV related to the administration of a plan and were thus preempted under ERISA. Specifically, Defendants set forth a Synopsis of Relevant Facts which stated that Herdrich was a participant and beneficiary in an employee benefit plan ("the Plan") provided to her through her husband's employer, State Farm Insurance Companies. The factual synopsis also asserted that Defendant Health Alliance was the administrator and fiduciary of the Plan. Finally, Defendants contended that as part of the Plan, Health Alliance contracted with Carle Clinic to provide medical care to Plan participants in accordance with an agreed upon fee schedule. In response to Herdrich's legal argument that Count IV was not preempted because it lacked the necessary relationship to an employee benefit plan, Defendants maintained that Plaintiff's reference to the Plan and Health Alliance's duty in her Addendum to the Complaint evidenced a relation between Count IV and the employee welfare benefit plan.

On July 22, 1994, Magistrate Judge Robert J. Kauffman recommended the Motion to Remand be denied. (Report and Recommendation, at 1). The Magistrate Judge found that Count IV related to an employee welfare benefit plan, and as

such, was preempted by ERISA. *Id.* at 2-3. The Magistrate did not find specifically that Count III was preempted. Neither party filed objections to the Magistrate's Report and Recommendation, and this Court adopted the Magistrate's Report and Recommendation, denying the Motion to Remand on August 5, 1994.

Discussion

A motion for summary judgment will be granted where there are no genuine issues of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). The moving party has the responsibility of informing the court of portions of the record or affidavits that demonstrate the absence of a triable issue. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 2552 (1986). The moving party may meet its burden of showing an absence of material facts by demonstrating "that there is an absence of evidence to support the non-moving party's case." *Id.*, at 325, 106 S.Ct. at 2553. Any doubt as to the existence of a genuine issue for trial is resolved against the moving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255, 106 S.Ct. 2505, 2513 (1986); *Cain v. Lane*, 857 F.2d 1139, 1142 (7th Cir. 1988).

If the moving party meets its burden, the non-moving party then has the burden of presenting specific facts to show that there is a genuine issue of material fact. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586-87, 106 S.Ct. 1348, 1355-56 (1986). Federal Rule of Civil Procedure 56(e) requires the non-moving party to go beyond the pleadings and produce evidence of a genuine issue for trial. *Celotex Corp.*, 477 U.S. at 324, 106 S.Ct. at 2553. This Court must then determine whether there is a need for trial—whether, in other words, there are any genuine factual issues that properly can be resolved only by a finder of fact because they

may be reasonably resolved in favor of either party. *Anderson*, 477 U.S. at 250, 106 S.Ct. at 2511.

Defendants submit that the Plan, through a subscription issued by Carle Clinic Health Maintenance Organization (Carle HMO), provided health and medical benefits to its participants and qualifies as an ERISA plan pursuant to 29 U.S.C. § 1001 *et seq*. Defendants assert that Plaintiff's contract with Health Alliance resulted solely from her enrollment in the Plan. Defendants contend, and Plaintiff does not deny, that all benefits provided for under the Plan were paid. Defendants state, without reference to supporting material, that Carle HMO acts as the fiduciary of the Plan. However, the Defendants also frame the issues contained in the Motion for Summary Judgment as "whether an ERISA plan participant/beneficiary may sue an ERISA plan fiduciary under Illinois common law and under the Illinois Consumer Fraud Act, 815 ILCS 505/1, *et seq*., to recover extra-contractual damages," indicating that Carle Clinic and Health Alliance function as fiduciaries. This statement, taken in conjunction with the prior representations made by Defendants, indicates that there are three fiduciaries of the Plan: Carle Clinic, Health Alliance, and Carle HMO. Defendants' primary argument in support of it's Motion for Summary Judgment, as to Count IV, is that regardless of who functions as the fiduciary, Plaintiff is not entitled to extracontractual damages under ERISA.

Herdrich claims that the Motion for Summary Judgment is "vague and ambiguous." She contends that Carle HMO is a product, not an entity and as such cannot qualify as a fiduciary under 29 U.S.C. § 1002(21)(A). She also submits that Carle Clinic is not a fiduciary as a matter of law and Defendants have failed to present evidence which supports their assertion that Carle Clinic is a fiduciary. Further, she argues that Health Alliance does not appear to be a fiduciary of the Plan as a

matter of fact. In support of this contention, Herdrich cites to Health Alliance's 1992 Annual Statement, filed with the Illinois Department of Insurance, which states that Health Alliance is not a "provider of administrative services or 'stop loss' group accident and health insurance to a multiple employer trust or multiple employer welfare arrangement." Herdrich submits that Carle Health Insurance Management Company ("CHIMCO") is, in fact, the fiduciary of the Plan. This Court will first address the issues raised by the parties in terms of Count IV, as neither the Magistrate Judge nor this Court have determined that Count III is preempted by ERISA. Then this Court will determine, for purposes of jurisdiction, whether Count III is preempted by ERISA.

A. Count IV

As there are serious questions about which organization(s) function as the fiduciary, this Court must determine whether this Plaintiff can recover the type of damages she seeks in Count IV, regardless of who exists as the fiduciary. Herdrich submits that ERISA provides for extracontractual damages in § 502(a)(3). Plaintiff cites *Blue Cross and Blue Shield of Alabama v. Lewis*, 753 F.Supp. 345, 347 (N.D.Ala. 1990), for the proposition that § 502(a) of ERISA allows for extracontractual, even punitive damages. Herdrich concedes, however, that the Seventh Circuit does not follow the holding in *Lewis*, stating that "[i]t is doubtful that the Seventh Circuit's refusal to follow the ruling of the Alabama District Court is justified since the Seventh Circuit apparently ignored the intent of Congress." (Mem. in Opposition to Summary Judgment, at 4).

Defendants cite the Supreme Court's holding in *Massachusetts Mutual Life Insurance Co. v. Russell*, 473 U.S. 134, 105 S.Ct 3085 (1985), for the proposition that ERISA

prohibits the award of extracontractual damages. ERISA's civil enforcement provision, § 502(a) provides, in relevant part,

> A civil action may be brought—
> (1) by a participant or beneficiary—
> (A) for the relief provided for in subsection (c) of this section, or
> (B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of his plan;
> (2) by the Secretary, or by a participant, beneficiary or fiduciary for appropriate relief under section 1109 of this title;
> (3) by a participant, beneficiary, or fiduciary (A) to enjoin any act or practice which violates any provision of this subchapter or the terms of the plan, or (B) to obtain other appropriate equitable relief (i) to redress such violations or (ii) to enforce any provisions of this subchapter or the terms of the plan.

29 U.S.C. § 1132(a). Section § 409, entitled Liability for breach of fiduciary duty states, in part,

> (a) Any person who is a fiduciary with respect to a plan who breaches any of the responsibilities, obligations, or duties imposed upon fiduciaries by this subchapter shall be personally liable to make good to such plan any losses to the plan resulting from each such breach, and to restore to such plan any profits of such fiduciary which have been made through use of assets of the plan by the fiduciary, and

> shall be subject to such other equitable or remedial relief as the court may deem appropriate, including removal of such fiduciary.

29 U.S.C. § 1109(a).

In *Russell*, the plaintiff received benefits under an employee welfare benefit plan for a back injury from May 1979 until October 17, 1979 when an orthopedic surgeon reported that the plaintiff was no longer disabled. *Russell*, 473 U.S. at 136. The plaintiff requested a review of the termination of her benefits and proffered a report from her psychiatrist ". . . indicating that she suffered from a psychosomatic disability with physical manifestations rather than an orthopedic illness." *Id.* When this report was confirmed by a second psychiatrist, the plan administrator reinstated plaintiff's benefits -- including a retroactive payment. *Id.* The plaintiff's suit, brought under § 502(a)(2), alleged that she sustained an injury "by the improper refusal to pay benefits from October 17, 1979, when her benefits were terminated, to March 11, 1980, when her eligibility was restored." *Id.*

The Court granted certiorari "to review both the compensatory and punitive components of the Court of Appeals holding that § 409 authorizes recovery of extracontractual damages." *Id.* at 138. The Court held that § 502(a)(2) authorizes a plan beneficiary to bring suit against a fiduciary under § 409. Any recovery for a breach of fiduciary duty, however, "inures to the benefit of the plan as a whole." *Id.* at 140. Further, the Court's decision states that within the context of §§ 502(a)(2) and 409, "we do not find in § 409 express authority for an award of extracontractual damages to a beneficiary." *Id.* at 144. The Court did not address whether a plan could recover extracontractual damages from a fiduciary under § 409. *Id.* at n.12. The Court noted that because the

plaintiff relied ". . . entirely on § 409(a), and expressly disclaimed reliance on § 502(a)(3), we have no occasion to consider whether any other provision of ERISA authorizes recovery of extra-contractual damages." *Id.* at 139, n.5. Therefore, regardless of the identity of the fiduciary, to the extent that Plaintiff seeks recovery of extracontractual damages under §§ 502(a) (2) and 409(a), summary judgment is granted in favor of the Defendants.

The plaintiff in *Russell* also argued that a private right of action for extracontractual damages should be implied absent an express authorization by ERISA. *Russell*, 473 U.S. at 145. The Court looked to the four-factor test employed by *Cort v. Ash*, 422 U.S. 66, 78 (1975), to determine whether an implied right of action for extracontractual damages exists under ERISA. *Id.* at 145. The Court declined to extend the *Ash* decision to "authorize the recovery of extracontractual damages. Because 'neither the statute nor the legislative history reveals a congressional intent to create a private right of action.'" *Id.* at 148 (quoting *Northwest Airlines. Inc. v. Transport Workers*, 451 U.S. 77, 94, n.31 (1981)). To the extent Herdrich argues for an implied right of action for extracontractual damages, the *Russell* case controls. No such right exists.

As the *Russell* decision left open the issue of whether § 502(a)(3) would permit recovery of extra-contractual damages, this Court must now turn to Plaintiff's argument that after the Supreme Court's decision in *Ingersoll-Rand Co. v. McClendon*, 111 S.Ct. 478 (1990), § 502(a)(3) should be found to allow for the recovery of extracontractual damages by a plan beneficiary. In *Harsch v. Eisenberg*, 956 F.2d 651 (7th Cir.), *cert. denied*, 113 S.Ct. 61 (1992), the plaintiffs filed a suit against their employer, a law firm, and the employee welfare benefit plan to which they belonged. *Harsch*, 956 F.2d

at 652-53. The plaintiffs alleged that their employer "had refused to comply with the plaintiffs' written request for information and claims for benefits, in violation of the terms of the plan, the policy and practices of the firm, and ERISA" and sought compensatory and punitive damages. *Id.* at 653. In holding that neither § 502(a)(1)(B) nor § 502(a)(3)(B) provided for compensatory damages, the *Harsch* court discussed the impact of *McClendon* on the *Russell* holding. *Id.* at 655, 659-660. The Seventh Circuit focused on the last paragraph of the *McClendon* opinion which states:

> [T]here is no basis in § 502(a)'s language for limiting ERISA actions to only those which seek "pension benefits." It is clear that the relief requested here is well within the power of the federal courts to provide. Consequently, it is no answer to a preemption argument that a particular plaintiff is not seeking the recovery of pension benefits.

Id. at 659 (quoting *McClendon*, 111 S.Ct. at 486). After summarizing the post-*McClendon* case law, including *Blue Cross and Blue Shield v. Lewis, supra,* the case our Plaintiff relies upon, and *International Union, United Automobile, Aerospace and Agricultural Implement Workers v. Midland Steel Products, Co.*, 771 F.Supp. 860, 863 (N.D.Ohio 1991), the Seventh Circuit concluded that the dicta from *McClendon* did not authorize the recovery of compensatory damages under § 502(a)(3). *Id.* at 660 ("we are not rash enough to believe that the Court intended to overrule settled law in most of the circuits, as well as narrowly limit—if not overrule—its own decision in *Russell* in such an off-hand manner").

As to the availability of punitive damages under either § 502(a)(1)(B) or § 502(a)(3), the *Harsch* court found neither

section of ERISA allowed for punitive damages. *Id.* at 661. Specifically as to § 502(a)(3), the court cited its prior holding in *Kleinhans v. Lisle Savings Profit Sharing Trust*, 810 F.2d 618, 627 (7th Cir. 1987) (punitive damages are not available under § 502(a)(3)). Other courts have relied upon *Harsch* in finding that § 502(a)(3) does not provide for extracontractual damages. *See, e.g., Lafoy v. HMO Colorado*, 988 F.2d 97, 99 (10th Cir. 1993); *Medina v. Anthem Life Ins. Co.*, 983 F.2d 29, 32 (5th Cir. 1993); *Zimmerman v. Sloss Equipment, Inc.*, 835 F.Supp. 1283, 1291 (D.Kan. 1993); *Pension Plan of Public Service Assoc. of New Hampshire et al. v. KPMG Peat Marwick*, 815 F.Supp. 52, 56-57, n.2 (D.N.H. 1993). Although Herdrich suggests that the Seventh Circuit's decision in *Harsch* is an incorrect reading of *Russell* and *McClendon*, this Court chooses to follow the Seventh Circuit's well reasoned holding.

Additionally, the Supreme Court has recently elaborated on the reference in § 502(a)(3)(B) to "other appropriate equitable relief." *Mertens v. Hewitt Assoc.*, 113 S.Ct. 2063 (1993). The Court granted certiorari to answer the question ". . . whether ERISA authorizes suits for money damages against non-fiduciaries who knowingly participate in a fiduciary's breach of fiduciary duty." *Id.* at 2066. In determining that a beneficiary may not recovery monetary damages from a non-fiduciary, the Court held that § 502(a)(3)(B) included typical remedies available in equity and not "legal remedies" like compensatory damages or monetary relief. *Id.* at 2069. The *Mertens* decision was limited to the type of damages which may be recovered under § 502(a)(3). *Amweiler v. American Elec. Power Service Corp.*, 3 F.3d 986, 993 (7th Cir. 1993). Thus, *Mertens* gives further support to this Court's conclusion that to the extent Herdrich relies on § 502(a)(3)(B) as a basis for monetary relief, as opposed to equitable relief, she may not proceed as a matter of law. This Court finds that Plaintiff's claim for extracontractual damages

against Defendant Health Alliance may not, as a matter of law, survive summary judgment. As this Court's finding is not specific to Health Alliance, but may be applied to any fiduciary, Plaintiff's Motion for Leave to Amend is denied as to Count IV.

B. Count III

As the Magistrate Judge left open the question of whether Count III of Plaintiff's Complaint is preempted, this Court must determine, as a jurisdictional matter, whether Count III is preempted by ERISA. If not, the matter should be remanded to State court. As set forth above, Count III alleges that Carle Clinic failed to disclose certain material facts regarding the ownership of Health Alliance in violation of the Illinois Consumer Fraud Act 815 ILCS 505/1 *et seq.* Specifically, Plaintiff claims that Carle Clinic sold her a subscription in Carle HMO through its wholly owned subsidiary Health Alliance. Plaintiff maintains that Defendant Carle Clinic violated the Consumer Fraud act by failing to advise her that the Carle HMO physicians hired by Health Alliance, in fact owned Health Alliance. Plaintiff also avers that Defendant Carle Clinic failed to inform her that the compensation of Carle HMO physicians was "increased to the extent that those physicians did not order diagnostic tests; did not utilize facilities not owned by those physicians; and did not make emergency or consultation referrals." (Addendum to Complaint, at 2). Count III seeks an amount in excess of $15,000.00 plus costs and attorney fees.

In ERISA's § 1, Congress articulated its declaration of policy, stating: ". . . to provide for the general welfare and free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans." 29 U.S.C. § 1001(a). In ERISA, Congress set out to

> "protect . . . participants in employee benefit plans . . . by requiring the disclosure and reporting to participants and beneficiaries of financial and other information with respect thereto, by establishing standards of conduct responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions and ready access to the Federal courts."

29 U.S.C. § 1001(b). Herdrich's claim in Count III is essentially that Defendants failed to disclose relevant, material information regarding the operation of the Plan. In order to find Count III preempted by ERISA, the State law which forms the basis of the claim must "relate to" an employee welfare benefit plan. 29 U.S.C. § 1144(a). The Supreme Court has given a broad interpretation to the "relate[s] to" requirement. In *Shaw v. Delta Air Lines*, 463 U.S. 85, 97, 103 S.Ct. 2890, 2900 (1983), the Court held that "a law 'relates to' an employee benefit plan in the normal sense of the phrase, if it has a connection with or reference to such plan." *Shaw*, 463 U.S. at 97.

ERISA contains detailed disclosure requirements. In § 101, the statute requires the administrator of each employee benefit plan to provide all participants with a summary plan description and fiscal statements and schedules. 29 U.S.C. § 1021(a). The summary plan description must include the following:

> The name and type of administration of the plan; the name and address of the person designated as agent for the service of legal process, if such person is not the administrator; the name and address of the administrator; names, titles, and addresses of any trustee or trustees (if they are

> persons different from the administrator); a description of the relevant provisions of an applicable collective bargaining agreement; the plan's requirements respecting eligibility for participation and benefits; a description of the provisions providing for nonforfeitable pension benefits; circumstances which may result in disqualification, ineligibility, or denial or loss of benefits; the source of financing of the plan and the identity of any organization through which benefits are provided; the date of the end of the plan year and whether the records of the plan are kept on a calendar, policy, or fiscal year basis; the procedures to be followed in presenting claims for benefits under the plan and the remedies available under the plan for the redress of claims which are denied in whole or in part.

29 U.S.C. § 1022(b). Additionally, ERISA requires each employee benefit plan publish an annual report, which is to be filed with the Secretary and made available to the plan participants and beneficiaries. 29 U.S.C. §§ 1023(a)(1)(A) and 1024(a) & (b) . The annual report must contain a financial statement and opinion. 29 U.S.C. § 1023 (a)(1)(B)(i). The financial opinion must issue from an independent qualified public accountant. 29 U.S.C. § 1023(a)(3)(A). The financial statement must include "a statement of assets and liabilities; a statement of changes in fund balance; and a statement of changes in financial position." 29 U.S.C. § 1023(b)(1). The notes accompanying the financial statement must contain the following disclosures:

> [A] description of the plan including any significant changes in the plan made during the

> period and the impact of such changes on benefits; a description of material lease commitments, other commitments, and contingent liabilities; a description of agreements and transactions with person known to be parties in interest; a general description of priorities upon termination of the plan; information concerning whether or not a tax ruling or determination letter has been obtained; and any other matters necessary to fully and fairly present the financial statements of the plan.

29 U.S.C. § 1023(b)(1). ERISA also dictates the schedules which must be attached to the financial statements. 29 U.S.C. § 1023(b)(3). The annual report must also contain an actuarial statement and opinion prepared by an enrolled actuary. 29 U.S.C. § 1023(a)(4)(A).

It is apparent from this brief review of ERISA's disclosure requirements that the statute comprehensively regulates the necessary disclosures. Count III seeks to impose additional disclosure requirements on the plan administrator other than those which are expressly enumerated in ERISA. This Court finds that under the broad reach of ERISA's § 514, Plaintiff's Count III relates to an employee benefit plan, and as such is preempted.

Having found Count III preempted, Herdrich must now allege which of ERISA's civil enforcement provisions, if any, would be provide a cause of action for Plaintiff. The availability of a federal remedy does not govern the preemption decision, and thus it may be that Plaintiff has no cause of action under ERISA. *Lister v. Stark*, 890 F.2d 941, 946 (7th Cir. 1989). Plaintiff is given leave to submit an amended Count III which

clearly sets forth her basis for proceeding under ERISA, including the applicable civil enforcement provision. If Plaintiff declines this opportunity, Count III will be dismissed with prejudice, and the remaining matters will be remanded to State Court.

Conclusion

For the reasons stated herein, the Motion for Summary Judgment as to Count IV is GRANTED in favor of Defendant Health Alliance Medical Plans, Inc. with costs. The Motion for Summary Judgment as to Count III is DENIED. The Plaintiff has fourteen (14) days to file her amended Complaint as to Count III, specifying under which of ERISA's civil enforcement provisions she intends to proceed. IT IS SO ORDERED.

ENTERED this 25th day of July, 1995.

/s/ Michael M. Mihm
Michael M. Mihm
Chief United States District Judge

APPENDIX F

UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF ILLINOIS

AMENDED
JUDGMENT IN A CIVIL CASE

CYNTHIA HERDRICH,

vs. Case Number 94-1143

LORI PEGRAM, M.D., CARLE CLINIC ASSOCIATION, HEALTH ALLIANCE MEDICAL PLANS, INC., and CARLE HEALTH INSURANCE MANAGEMENT CO., INC.

☒ JURY VERDICT. This action came before the Court for a trial by jury. The issues have been tried and the jury has rendered its verdict.

IT IS ORDERED AND ADJUDGED that defendants Health Alliance Medical Plans, Inc and Carle Health Insurance Company, Inc are dismissed on 4/15/96. Judgment is entered in favor of Plaintiff and against Defendants Lori Pegram and Carle Clinic Association as employer of defendant Lori Pegram in the amount of $50,000 total damages with 30% negligence attributable to Plaintiff Cynthia Herdrich with recoverable damages in the sum of $35,000.00, plus costs of

suit. Further that on 2/10/97, costs are taxed in favor of Plaintiff and against Defendants in the sum of $232.00.

ENTER this 10th day of February, 1997.

/s/ John Waters
JOHN M. WATERS, CLERK

/s/ H. Williams
BY: DEPUTY CLERK

APPENDIX G

IN THE UNITED STATES DISTRICT COURT
FOR THE CENTRAL DISTRICT OF ILLINOIS
PEORIA DIVISION

CYNTHIA HERDRICH,	)	
	)	
Plaintiff,	)	
	)	
vs.	)	No. 94-1143
	)	
LORI PEGRAM and CARLE CLINIC ASSOCIATION, HEALTH ALLIANCE MEDICAL PLANS, INC., CARLE HEALTH INSURANCE MANAGEMENT CO., INC.,	)	
	)	
Defendants.	)	

AMENDED COUNT III

NOW COMES plaintiff, CYNTHIA HERDRICH, by her attorneys, Hayes, Hammer, Miles, Cox and Ginzkey complaining of CARLE CLINIC ASSOCIATION, P.C. (hereinafter "CARLE"), HEALTH ALLIANCE MEDICAL PLANS, INC. (hereinafter "HAMP") and CARLE HEALTH INSURANCE MANAGEMENT CO., INC. (hereinafter "CHIMCO") as follows:

THE PARTIES

1. CARLE is an Illinois corporation comprised of owner/physicians and is doing business in the central district of Illinois.

2. HAMP is a for-profit Illinois Domestic Stock Insurance Company doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.

3. CHIMCO is a for-profit Illinois corporation doing business in the central district of Illinois and is a wholly-owned subsidiary of CARLE.

JURISDICTION

4. This court has jurisdiction pursuant to 29 USC 1101, 1109 and 1132(a).

THE FACTS

5. In March of 1991 and thereafter, plaintiff's husband was employed by State Farm Mutual Automobile Insurance Company (hereinafter "State Farm").

6. Prior to March of 1991 and annually thereafter, for valuable consideration, through State Farm, defendants sold plaintiff a subscription in CARLE CARE HMO, a pre-paid health insurance plan (hereinafter "the Plan") arranging medical and hospital services for subscribers (see attached Exhibit A).

7. State Farm retained no right to direct or control the administration of the Plan.

8. Defendants have the exclusive right to decide all disputed and non-routine claims under the Plan.

9. Under the Plan, defendants exercise discretionary authority and discretionary control of claims management, property and asset management, and administration of the Plan.

10. Defendant is a participant and beneficiary under the Plan and brings this action on behalf of the Plan pursuant to 29 USC 1132(a).

11. Defendants are fiduciaries with respect to the Plan and under 29 USC 1109(a) are obligated to discharge their duties with respect to the Plan solely in the interest of the participants and beneficiaries and

    a. for the exclusive purpose of:

        i. providing benefits to participants and their beneficiaries; and

        ii. defraying reasonable expenses of administering the Plan;

    b. with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and like aims.

12. In breach of that duty:

a. CARLE owner/physicians are the officers and directors of HAMP and CHIMCO and receive a year-end distribution, based in large part upon, supplemental medical expense payments made to CARLE by HAMP and CHIMCO;

b. Both HAMP and CHIMCO are directed and controlled by CARLE owner/physicians and seek to fund their supplemental medical expense payments to CARLE:

i. by contracting with CARLE owner/physicians to provide the medical services contemplated in the Plan and then having those contracted owner/physicians:

(1) minimize the use of diagnostic tests;
(2) minimize the use of facilities not owned by CARLE; and
(3) minimize the use of emergency and non-emergency consultation and/or referrals to non-contracted physicians.

ii. by administering disputed and non-routine health insurance claims and determining:

(1) which claims are covered under the Plan and to what extent;
(2) what the applicable standard of care is;
(3) whether a course of treatment is experimental;
(4) whether a course of treatment is reasonable and customary; and
(5) whether a medical condition is an emergency.

13. As a direct and proximate result of defendants' breach of their fiduciary duties, the Plan has been deprived of those sums comprising the supplemental medical expenses made by HAMP and CHIMCO to CARLE, as well as those amounts which would have been realized by prudently investing those supplemental medical expenses.

WHEREFORE, plaintiff prays an order of this court:

a. Requiring CARLE to reimburse the supplemental medical expense payments received from HAMP and CHIMCO, and a reasonable rate of return thereon;

b. For an award of court costs and attorney fees; and

c. For such other equitable relief as this court deems just.

CYNTHIA HERDRICH, plaintiff

BY: /s/ James P. Ginzkey
One of her attorneys

James P. Ginzkey
HAYES, HAMMER, MILES, COX & GINZKEY
202 North Center Street
Bloomington, Illinois 61701
309/828-7331

STATE OF ILLINOIS)
) ss.
COUNTY OF McLEAN)

PROOF OF SERVICE

The undersigned certifies that the foregoing instrument was served upon all parties to the above cause by (U.S. Mail) (~~Federal Express~~) (~~hand delivering~~) a copy thereof to:

Peter W. Brandt
Livingston Law Firm
115 West Jefferson Street
Bloomington, Illinois 61701

the attorney of record herein at his respective address as disclosed on the pleadings, on August 4, 1995 .

/s/ Donna M. Hansen

Subscribed and sworn to before me this
4th day of August ,
1995 .

/s/ Tami J. Grizzle
Notary Public

CarleCare **EXHIBIT A**
Health Maintenance Organization
602 West University Avenue
Urbana, IL 61801 (217) 337-8000

HERDRICH, RICK L. **Member Subscription**
207 S EVERGREEN LN **Certificate**
BLOOMINGTON, IL 61704

This Subscription Certificate, supplemented by the Face Sheet, Amendments and/or Riders attached hereto, in combination with the Employer Enrollment Agreement (if applicable) and the Application (if attached) constitute the entire agreement between the Subscriber named herein and CarleCare, Inc.

CarleCare is certified under the State of Illinois HMO Act of 1974 and holds a Certificate of Authority to do business as a prepaid health maintenance organization in the states of Illinois and Indiana.

This document specifies the benefits which the Subscriber and Eligible Dependents are entitled to receive as Members of CarleCare in consideration of the specified premiums paid by or on their behalf.

IN WITNESS WHEREOF, CarleCare, Inc.
has duly executed this certificate.

/s/ Harlan J. Fairlor, MD
Harlan J. Fairlor, MD
President

GROUP
SUBSCRIPTION CERTIFICATE FACESHEET

GROUP NUMBER 00229
GROUP NAME STATE FARM CORPORATE HEADQTRS

ID NUMBER 961040-00229

SUBSCRIBER EFF. DATE 1/01/90

HERDRICH RICK L
207 S EVERGREEN LN
BLOOMINGTON, IL 61704

SCHEDULE OF BENEFIT AND CO-PAYMENT LIMITS*

HOSPITAL INPATIENT - UNLIMITED DAYS PER DISABILITY - $100
CO-PAYMENT PER DAY - MAXIMUM $100 CO-PAYMENT PER HOSPITALIZATION.

INPATIENT MENTAL HEALTH - 30 DAYS PER COVERAGE YEAR WITH A $100 CO-PAYMENT PER HOSPITALIZATION.

OUTPATIENT MENTAL HEALTH - UP TO 30 VISITS PER COVERAGE YEAR WITH A $15 CO-PAYMENT PER VISIT.

INPATIENT SUBSTANCE ABUSE - UP TO 30 DAYS PER COVERAGE YEAR WITH A $100 CO-PAYMENT PER HOSPITALIZATION.

OUTPATIENT SUBSTANCE ABUSE - UP TO 20 VISITS PER COVERAGE YEAR WITH A $0 CO-PAYMENT PER VISIT.

DURABLE MEDICAL EQUIPMENT - PROVIDED WITH A 20% CO-PAYMENT.

PODIATRY WILL BE PROVIDED WITH A $0 CO-PAYMENT.

PROSTHETIC DEVICE - PROVIDED WITH A 20% CO-PAYMENT.

DIAGNOSTIC EVALUATION/TREATMENT OF INFERTILITY PROVIDED WITH 50% CO-PAYMENT.

OUTPATIENT PHYSICIAN VISITS - $0 CO-PAYMENT PER VISIT.

EMERGENCY ROOM VISITS $20 CO-PAYMENT PER VISIT.

ELECTIVE EPIDURAL ANESTHESIA FOR LABOR PAIN MANAGEMENT IS COVERED WITH A 50% CO-PAYMENT.

REFRACTORY EYE EXAMS FOR MEMBERS 17 YEARS OF AGE AND UNDER ARE PROVIDED WITH A $0 CO-PAYMENT PER VISIT.

REFRACTORY EYE EXAMS FOR MEMBERS 18 YEARS OF AGE AND OVER ARE PROVIDED WITH A $0 CO-PAYMENT PER VISIT.

MAXIMUM OUT-OF-POCKET EXPENSES FOR CO-PAYMENTS AS DESCRIBED HEREIN SHALL NOT EXCEED 100% OF THE AVERAGE ANNUAL PREMIUM PER MEMBER PER CONTRACT YEAR.

GROUP SUBSCRIPTION CERTIFICATE AMENDMENTS
STATE FARM CORPORATE HEADQTRS

*AMENDMENTS: SECTION 2.2 SUBSTITUTE "UNMARRIED CHILD" WITH "NEVER MARRIED CHILD". DELETE "UNDER THE AGE OF NINETEEN (19) . . . IS EARLIER," SUBSTITUTE "UNDER THE AGE OF TWENTY-THREE (23)". SUBSTITUTE "AGE NINETEEN (19)" WITH "AGE TWENTY THREE (23). SECTION 4.9 SUBSTITUTE "NINETEENTH (19) BIRTHDAY" WITH "TWENTY-THIRD (23) BIRTHDAY" AND "LAST DAY OF THE MONTH" WITH "LAST DAY OF THE YEAR" DELETE "ENROLLED . . . , OR".

GROUP SUBSCRIPTION CERTIFICATE

Introduction

CarleCare HMO, a product of Health Alliance Medical Plans, Inc., is organized as a health maintenance organization to do business as a prepaid health plan in Illinois and Indiana. In consideration of the payment of premiums by or on behalf of the Subscriber, CarleCare HMO agrees to arrange for medical and hospital services and other health care services to the Subscriber in accordance with the Subscription Certificate, hereinafter "Certificate," including amendments, modifications and limitations set forth in the attached Face Sheet and any attachments herewith. Eligibility for benefits starts on the stated effective date and remains in effect for the remainder of the Group contract year unless earlier cancelled or terminated. This Certificate will be extended in its present form from contract year to contract year without further action unless notification to the contrary is given.

Section 1. DEFINITIONS

The following definitions apply to all provisions of this Certificate.

1.1 **CarleCare HMO** (hereinafter referred to as CarleCare) shall mean a health maintenance organization organized as a product of Health Alliance Medical Plans, Inc., and Illinois domestic stock insurance company.

1.2 **Group** shall mean the employer, association, union or other group as stated on the Face Sheet of this Certificate.

1.3 **Group Enrollment Agreement** shall mean the contract of which this certificate is a part between CarleCare and the Group whereby coverage is elected by the Group for those Subscribers and Family Dependent(s) enrolled hereunder.

1.4 **Subscriber** shall mean a person meeting the requirements of Section 2.1 who has enrolled in CarleCare and for whom the current premium payments have been received.

1.5 **Family Dependent(s)** shall mean a member of the family of a Subscriber as defined in Section 2.2.

1.6 **Member** shall mean either a Subscriber or a Family Dependent(s).

1.7 **Physician** shall mean a person licensed to practice medicine in all of its branches in the states of Illinois and Indiana.

1.8 **CarleCare Physician** means a Physician who is a member of, employed by or formally associated with a medical group having a contract to provide services to CarleCare Members.

1.9 **Primary Care Physician** means a CarleCare Physician selected by or on behalf of a Member to provide, arrange and coordinate a Member's care.

1.10 **General Service Area** shall mean Champaign, Clark, Coles, Crawford, Cumberland, DeWitt, Douglas, Edgar, Effingham, Ford, Iroquois, Jasper, Kankakee, Livingston, Macon, McLean, Moultrie, Piatt, Shelby and Vermilion counties in Illinois and Benton, Fountain, Newton, Montgomery, Parke, Vermillion, Vigo and Warren counties in Indiana.

1.11 **Family Coverage** shall mean the coverage provided for a Subscriber and his/her Family Dependent(s) by or on whose behalf the applicable family premium has been paid.

1.12 **Open Enrollment Period** means a period of time determined by CarleCare and the Group during which eligible Group members who have not previously enrolled in CarleCare may do so without evidence of insurability or of good health.

1.13 **Co-Payment** means a money payment required to be paid by or on behalf of a Member for certain services at the time and place such services are received. The schedule of Co-Payments is set forth in the Face Sheet of this Certificate. Total Co-Payments paid by or on behalf of a Member during a contract year shall not exceed 100% of the total annual premium for individual or Family Coverage, whichever is applicable, for one coverage year of the health care services provided under this Certificate or shall never exceed fifty (50) percent of a particular covered service. Provided application is made to CarleCare by the Subscriber within forty-five (45) days of the end of the coverage year to which such limitation applies, any excess in the amount of Co-Payments shall be refunded to the Subscriber.

1.14 **Medically Necessary** means the services, care or supplies which are required to identify or treat a Member's condition and is: (1) consistent with the symptom or diagnosis and treatment or distinct improvement of a Member's condition; (2) in accordance with standards of good medical practice; (3) not mainly for convenience of the Member, a Physician or other provider; and (4) the most appropriate medical service, supply or level of care which can safely be provided.

When applied to inpatient care, it further means that the Member's medical symptoms or condition require that the services cannot be safely provided to the Member as an outpatient.

1.15 **Substance Abuse** shall mean the uncontrollable or excessive abuse of addictive substances and the resultant physiological or psychological dependency which develops with continued use and for which the Primary Care Physician determines that medical care is required. The addictive substances included under Substance abuse are limited to alcohol, morphine, cocaine, opium, and other barbiturates and amphetamines.

Section 2.
ELIGIBILITY AND ENROLLMENT

Individuals eligible for enrollment must meet the following requirements.

2.1 Subscriber: To be eligible as a CarleCare Subscriber, an individual must be either an actual and bona fide member of the enrolled Group or be entitled by agreement, contract or other established standard to participate in insurance benefits arranged by the Group and so certified by the Group.

2.2 Family Dependent(s): To be eligible to enroll in CarleCare as a Family Dependent(s), an individual must be either:

- the spouse of a Subscriber, or

- a dependent, unmarried child under the age of nineteen (19) unless enrolled as a full-time student in which case

coverage may continue through the last day of the month of graduation or cessation of studies or age twenty-three (23), whichever is earlier; this refers to natural and adopted children of the Subscriber, stepchildren who reside on a full-time basis with the Subscriber, as well as to children for whom the Subscriber is the legal guardian and who is eligible to be claimed as a dependent for federal income tax purposes by the Subscriber.

A dependent who attains the age of nineteen (19) and is both (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the Subscriber for support and maintenance will continue to be included under Family Coverage for the duration of the disability and dependency. The Subscriber shall submit documentary proof of disability and dependency when requested by CarleCare at specified intervals. These intervals are defined as every six (6) months for the first two (2) years after the date of the first request for service on behalf of the disabled and dependent person or from the date on which CarleCare is notified of the dependent's disability and dependency, whichever is earlier and annually thereafter.

2.3 A newly married Subscriber arranges for addition of spouse to Family Coverage by submitting request to CarleCare within 31 days of the marriage.

2.4 A newborn child of a Subscriber is automatically covered for 31 days after birth subject to the applicable premiums for such coverage. Coverage for a newborn shall include illness, injury, congenital defects, birth abnormalities and premature birth. To continue coverage of a newborn, a request for addition to a family membership (or a conversion from individual to family membership) must be submitted to

CarleCare within 31 days of birth. Premium for continued coverage of a newborn shall be payable from the date of birth.

2.5 During an Open Enrollment Period, subscribers and family dependents meeting the requirement of Section 2.1 and 2.2 may enroll in CarleCare by submitting completed applications on forms provided by CarleCare. No person is eligible to re-enroll hereunder who has had coverage terminated under Sections 4.5, 4.6, 4.7, or 4.8.

Section 3. PAYMENT FOR SERVICES FOR ENROLLED GROUP

3.1 Payment for services covered by this Certificate shall be made as follows: the Subscriber or anyone paying on his or her behalf shall remit to CarleCare monthly, the specified premium rate. Only a Member for whom the premium is actually received by CarleCare shall be entitled to the benefits of this Certificate and only for the month for which such payment is received.

3.2 The monthly premium rate shall be effective for a twelve month period of time and shall be subject to revision thereafter on a yearly basis as of the group's anniversary date. Notice of such revision in premium rate shall be provided to the Group not less than 60 days prior to the effective date of such revision.

3.3 The first monthly premium must be paid on or before the effective date of this Certificate and the succeeding premiums must be paid on or before the first day of each succeeding month in order for the benefits to be payable subject to the grace period provisions specified in Section 3.4.

3.4 If the Subscriber or anyone paying on his or her behalf fails to pay the premium within 31 days after it becomes due, this Certificate is automatically cancelled and covered members are not entitled to further benefits. If a Subscriber terminates employment with the Group, coverage under this Certificate shall terminate after the last day of the period for which the premium has been paid. A Subscriber who becomes ineligible for continued membership in the Group while the coverage agreement between CarleCare and the Group is in effect may be eligible for conversion to a direct payment plan as provided in Section 9.5.

Section 4. TERM AND TERMINATION OF AGREEMENT

4.1 The effective date of this Certificate is stated on the Face Sheet. The duration of this Certificate is for one year from the group's anniversary date, and it automatically will be renewed from Group year to Group year unless earlier cancelled or terminated.

4.2 Termination of this Certificate by either Group or by CarleCare may be accomplished at any time by termination of the Group Enrollment Agreement or by giving written notice of termination to the other party at least 60 days prior to the effective date of termination. The Group shall be responsible for notifying Members of termination of the Certificate under this Section 4.2.

4.3 Termination by CarleCare. In the event that CarleCare terminates this Certificate pursuant to Section 4.2, any member who is hospitalized at the effective date of termination shall receive the following benefits: all services otherwise available hereunder to patients, for the condition

under treatment, during the remainder of that particular episode of hospitalization, until determination by a Physician that hospitalization is no longer medically indicated. In maternity cases under care at the effective date of termination, CarleCare may at its election either (a) continue obstetrical care only through confinement and discharge, or (b) convert the Member from the Group to individual enrollment. Except as expressly provided in this subsection, all rights to benefits and services shall cease as of the effective date of termination.

4.4 Termination by the Group. In the event that the Group terminates this Certificate pursuant to Section 4.2, then all rights to benefits and services shall cease as of the effective date of termination.

4.5 CarleCare may terminate the rights of a Subscriber and covered Family Dependent(s) of the Subscriber for the following reasons only after affording the Subscriber a hearing before the Patient Satisfaction Committee of CarleCare and upon that Committee's recommendation: (a) willful provision of a CarleCare membership identification card to any person ineligible for CarleCare services; (b) failure to make payment to CarleCare within thirty (30) days of charges for non-covered services or of Co-Payments required for covered services; (c) permanent residency changes to an area not included in Section 1.9.

4.6 CarleCare may terminate the rights of a Subscriber and covered Family Dependent(s) of the Subscriber by reason of the unreasonable refusal of the said Subscriber or Family Dependent(s) of the Subscriber to follow a prescribed course of treatment. Coverage may be terminated under this subsection only upon thirty (30) days prior written notice.

4.7 CarleCare may terminate the rights of the Subscriber and covered Family Dependent(s) of the Subscriber as of the effective date of enrollment by reason of fraud or material misrepresentation in enrollment, or as of the date of discovery of fraud or misrepresentation in the use of services or facilities provided under this Certificate.

4.8 CarleCare may terminate the rights of the Subscriber and covered Family Dependent(s) of the Subscriber by reason of any material violation of the terms of this Certificate by the Subscriber or any Family Dependent(s) of the Subscriber.

4.9 The dependent coverage of a child terminates on the last day of the month of his/her nineteenth (19) birthday unless the child is enrolled as a full-time student, in which case coverage may continue through the last day of the month of graduation or cessation of studies or age twenty-three (23), whichever is earlier, or (a) incapable of self-sustaining employment by reason of mental retardation or physical handicap and (b) chiefly dependent upon the Subscriber for support and maintenance in which case such child will continue to be included under Family Coverage for the duration of the disability and dependency.

Section 5. PHYSICIAN-PATIENT RELATIONSHIP

5.1 The Primary Care Physicians shall maintain traditional physician-patient relationships with Members. Every Member will be asked to select a Primary Care Physician at the time of enrollment. Changing Primary Care Physicians is permissible at any time by writing CarleCare.

5.2 Information from medical records and information received by Physicians incidental to the physician-patient relationship shall be kept confidential. It shall not be disclosed without the written consent of the Member, or if the Member is a minor, without the written consent of Member's parent or legal guardian.

Section 6. SERVICE SCHEDULE

The following Service Schedule specifies the services which the Subscriber and his/her enrolled Family Dependent(s) are entitled to receive as Members of CarleCare. All services are provided subject to the Limitations and Exclusions (see Sections 7 and 8) and in accordance with accepted medical and surgical practices and standards approved by the Medical Policy Committee of CarleCare and in conjunction with the Primary Care Physician.

6.1 CarleCare Physician Services - Outpatient

Diagnostic and treatment services are covered according to the provisions of Section 1.13. This coverage is subject to the exclusions in Section 8 and any Co-Payment per visit indicated on the Face Sheet of this Certificate. Preventive medical services, including the recommended periodic health care examinations and well baby care are covered when provided by the Primary Care Physician.

6.2 Physician Services - In Hospital

All covered services provided by CarleCare Physicians, including surgical procedures, anesthesia and consultant services, are provided when a Member is hospitalized subject to any Co-Payment indicated on the Face Sheet of this Certificate.

6.3 Hospital Care

Hospital services are provided for an unlimited number of days when hospitalization is ordered by the Primary Care Physician subject to any Co-Payment as set forth on the Face Sheet of this Certificate. (See Section 6.8 for information on inpatient mental health care and Section 6.10 on alcoholism, drug addiction/abuse). Except as noted in the exclusions, all hospital services are provided, including private duty nurses, when a CarleCare Physician determines that this type of care is Medically Necessary.

Members shall be hospitalized in semi-private (two-bed) accommodations unless it is Medically Necessary (as authorized by a CarleCare Physician) to occupy a private room (one-bed).

6.4 Skilled Nursing Facility

Inpatient services in an approved Skilled Nursing Facility are covered in full for a maximum of 120 days per Member per contract year when prescribed by the Primary Care Physician and authorized in advance by the Health Services Department. Custodial or convalescent care are not covered (see Section 8.7).

6.5 X-ray and Laboratory

All X-ray and laboratory tests and services approved by the CarleCare Medical Policy Committee are covered when Medically Necessary, requested by the CarleCare Physician and obtained at an approved CarleCare facility.

6.6 Maternity Care

Physician and hospital maternity care is provided when requested by a CarleCare Physician subject to any Co-Payment indicated on the Face Sheet of this Certificate.

6.7 Family Planning Services

Family Planning Services and consultation by CarleCare providers are a covered benefit. Covered diagnostic evaluation and treatment of infertility is subject to the Co-Payment specified for infertility on the Face Sheet of this Certificate (See Section 8.14 for information on exclusions.) This Co-Payment is applicable to outpatient care, inpatient care and infertility drugs. Outpatient infertility drugs are excluded for those members who do not have the prescription drug benefit.

Elective sterilization procedures (i.e. tubal ligations and vasectomies) are covered. Elective abortions and surgical procedures performed for reversal of voluntary sterilizations are not covered (see Sections 8.12 and 8.13).

6.8 Mental Health Care - Inpatient

Inpatient mental health services are provided as may be necessary and appropriate for short-term evaluation and/or crisis intervention. Up to twenty (20) days inpatient services, or the number set forth on the Face Sheet of this Certificate, shall be provided per member per contract year, subject to the co-payment set forth on the Face Sheet of this Certificate when authorized by the Primary Care Physician.

6.9 Mental Health Care - Outpatient

Outpatient mental health services shall be provided for short-term evaluation and/or crisis intervention. Up to twenty (20) outpatient visits, or the number set forth on the Face Sheet of this Certificate, per member per contract year, subject to the co-payment per visit set forth on the Face Sheet of the Certificate will be provided, when authorized by the Primary Care Physician. There will be no co-payment for initial evaluation. These services may be provided by a Physician, by a registered clinical psychologist, or by ancillary mental health

professionals under supervision of a Physician or registered clinical psychologist.

6.10 Substance Abuse

Diagnosis and the medical non-psychiatric treatment of Substance Abuse, such as detoxification, is provided on an unlimited basis when authorized by the Primary Care Physician.

Unless otherwise stated on the Face Sheet of this Certificate, coverage for Substance Abuse rehabilitation on an inpatient basis is subject to the limitations specified for treatment of Mental Health - Inpatient in Section 6.8 of the Certificate. The number of days used for Substance Abuse rehabilitation will reduce the number of days available for inpatient Mental Health treatment. Inpatient rehabilitation coverage does not include programs consisting primarily of counseling by individuals other than a Physician or Registered Clinical Psychologist, court ordered evaluations, care in lieu of detention or correctional placement, or Family retreats.

Unless otherwise stated on the Face Sheet of this Certificate, coverage for Substance Abuse rehabilitation on an outpatient basis is subject to the limitations specified for treatment of Mental Health Care - Outpatient in Section 6.9 of this Certificate. The number of visits used for Substance Abuse rehabilitation will reduce the number of visits available for outpatient Mental Health treatment.

6.11 Oral Surgery

Although general dental services are not provided, oral surgical procedures which are Medically Necessary and coordinated through the Health Services Department will be provided when authorized by the Primary Care Physician in connection with the following limited

conditions: traumatic injury to sound natural teeth within thirty (30) days of injury; traumatic injury to the jaw bones or surrounding tissue; or correction of a non-dental pathological condition such as cysts and tumors.

6.12 Eye Examinations and Hearing Tests

Vision and hearing screenings provided by the Primary Care Physician are covered for all Members. Examinations for prescribing glasses or for determining the refractive state of the eyes are covered for children through age 17 when ordered by the Primary Care Physician subject to the copayment specified on the Face Sheet of this Certificate.

Unless otherwise indicated on the Face Sheet of this Certificate, examinations for prescribing glasses or for determining the refractive state of the eyes are not covered for Members eighteen (18) years of age or older (See exclusions Section 8.15).

6.13 Physical Therapy and Rehabilitation Medicine

Rehabilitation therapy for conditions incurred due to illness, injury or surgery is a service performed by a licensed physical therapist, occupational therapist or speech therapist. Inpatient and outpatient treatment is limited to up to sixty (60) treatments per condition when, in the judgment of the Primary Care Physician, significant improvement can be expected in the Member's condition.

6.14 Injections and Immunizations, Dressings and Casts

Injections, immunizations, dressings, splints and casts are covered when administered by a CarleCare physician or by a nurse or other health professional under the direction of a CarleCare Physician. Self-administered dressings and other

disposable supplies, such as chemstrips and lancets, are not covered.

6.15 Restorative Plastic Surgery

Coverage is limited to Medically Necessary services when authorized by a Primary Care Physician to correct a functional defect which resulted from an acquired and/or congenital disease or injury. Cosmetic surgery to correct congenital anomalies in newborns is covered.

6.16 Home Health Services

Intermittent skilled nursing and skilled therapeutic home services are provided in full when under the direction and approval of a CarleCare Physician. Coverage must be authorized by the Health Services Department.

6.17 Ambulance Service

Ambulance services are provided when authorized by the CarleCare Physician or for traumatic injury or medical condition as described in Section 6.18. Such authorization will be given only when such services are Medically Necessary.

6.18 Emergency Medical Care

All care authorized by a CarleCare physician for an emergency condition is covered. A medical emergency is defined as a traumatic injury or medical condition which occurs unexpectedly and which, if not immediately treated, might cause complications or jeopardize the Member's full recovery. Heart attacks, cerebral vascular accidents (strokes), poisonings, loss of consciousness and convulsions are considered to be "medical emergencies." Similar conditions may also be determined by the Primary Care Physician to be medical emergencies.

A. **In the Service Area**

Unless the life or health of the Member would be in immediate danger if treatment was delayed, CarleCare Members are required to contact their Physician or designated ancillary health professional and follow their instructions. Visits to an emergency room are subject to a Co-Payment by the Subscriber as shown on the Face Sheet of this Certificate.

B. **Outside the Service Area**

A CarleCare Member requiring emergency medical or hospital care while temporarily outside the Service Area is covered. Out-of-area benefits are limited to payment or reimbursement of usual, customary and reasonable charges for emergency care required before the member can, without medically harmful results, return to the Service Area. Elective care or care required as a result of circumstances which could reasonably have been foreseen prior to departure from the Service Area are not covered. Payment will be made for unexpected hospitalization due to complications of pregnancy. Routine delivery at term outside the Service Area, however, will not be covered unless the Member is outside of the Service Area due to circumstances beyond her control. Out-of-area emergency room visits are subject to a Co-Payment as shown on the Face Sheet of this Certificate.

A CarleCare Member receiving emergency services either within the Service Area or outside the Service Area from non-CarleCare Physicians or hospitals is required to notify CarleCare within 48 hours, or as soon as reasonably possible, after care begins.

6.19 **Health Education**

Upon referral from a CarleCare Physician, health education services, including instruction in personal health care, management of health problems and information about the best

use of CarleCare facilities and services are available. A current list of covered health education classes will be available at the offices of CarleCare upon request of any Member.

6.20 **Medical Social Services**

Medical social services include discharge counseling, referrals to community service agencies and other related services to assist the Member and family in coping with the medical condition.

6.21 **Durable Medical Equipment**

Corrective and orthopedic appliances (such as leg braces, jobst stockings, knee sleeves) and durable medical equipment for home use (such as non-motorized wheelchairs, surgical beds, oxygen equipment) will be provided subject to any Co-Payment specified on the Face Sheet of this Certificate when determined to be Medically Necessary due to an injury, illness, or medical condition of the Member occuring while the Member was enrolled in CarleCare.

Items and supplies provided under this section must be prescribed by the Primary Care Physician and authorized in advance by the Health Services Department. Equipment will be made available to Members from CarleCare authorized providers through rental or purchase agreements, at the option of CarleCare.

To accord with changes in medical technology, CarleCare will maintain a list of items which are not covered under this benefit or which are covered only with advance written approval by the Medical Director of CarleCare.

6.22 **Prostheses and Implants**

Prosthetic devices (such as artificial limbs) and penile implants are subject to any Co-Payment specified on the

Face Sheet of this Certificate. Coverage will be provided for such items when determined to be Medically Necessary due to an injury, illness, or medical condition of the Member occurring while the Member was enrolled in CarleCare. Items provided under this section must be prescribed by the Primary Care Physician and authorized in advance by the Health Services Department.

To accord with changes in medical technology, CarleCare will maintain a list of items which are not covered under this benefit or which are covered only with advance written approval by the Medical Director of CarleCare.

6.23 **Sexual Assault or Abuse Victims**

Hospital and medical services that are an emergency shall be provided to the full extent of coverage without Co-Payment, if any, as set forth on the Face Sheet of this Certificate, for sexual assault or abuse victims.

6.24 **Human Organ Transplants**

Upon prior order or written referral of the Primary Care Physician, benefits will be provided for a liver organ or tissue transplant to an unmarried dependent child under the limiting age specified in the Subscription Certificate if Family Coverage is in force and if the organ or tissue transplant is necessitated because the unmarried dependent child has biliary atresia. In addition, benefits will be provided for cornea and kidney organ or tissue transplants. No organ or tissue not specifically named as covered in this Subscription Certificate or any Rider attached hereto, shall be eligible for Human Organ Transplant benefits.

6.25 **Podiatry Services**

Podiatry Services, when medically necessary and provided by an affiliated podiatrist, are covered when authorized by the Primary Care Physician subject to any Co-Payment per visit as set forth on the Face Sheet of this Certificate.

Section 7. LIMITATIONS

7.1 **Circumstances Beyond Control**

To the extent that a natural disaster, war, riot, civil insurrection, epidemic or any other emergency or similar event not within the control of CarleCare results in the facilities, personnel or financial resources of CarleCare being unavailable to provide or arrange for the provision of a basic or supplemental health service in accordance with the requirements of this subpart, CarleCare is required only to make a good-faith effort to provide or arrange for the provision of the service, taking into account the impact of the event. NOTE: Language taken from Section 110.102(b) of the Federal Register.

7.2 **Non-CarleCare Physician Services**

Diagnostic and treatment services by non-CarleCare Physicians are provided only when referred by the Primary Care Physician and require prior written authorization from the CarleCare Medical Director except as stated in Section 6.18, Emergency Medical Care.

7.3 **Coordination of Benefits**

A. All benefits and services under this Certificate are subject to a Coordination of Benefits limitation. When a beneficiary holds two or more health plans, benefits provided under the other plan shall be coordinated with

those provided under this Subscription Certificate. This includes benefits available under automobile no-fault and medical payments coverage as well as homeowner's insurance.

B. Necessary definitions include the following:

1. Other Plan means any Group arrangment other than this Certificate which provides a Member with hospital, medical, surgical or dental benefits and which consists of employer-sponsored Group insurance coverage, association-sponsored Group prepayment coverage, coverage under labor-management trusteed plans, employer organization plans or employee benefit organization plans, or coverage under governmental programs or coverage required or provided by statute, but not student accident policies or Group franchise plans.

2. Allowable Benefits means the sum of each necessary, reasonable and customary item of expense incurred by a beneficiary, at least a portion of which is covered by this Certificate or some other Plan covering the Member. When a service provided is not otherwise valued in terms of money, then the reasonable cash value shall be deemed to be the benefit.

3. One Year Period means the period of twelve (12) consecutive months commencing on the first day on which a Member incurs an item of allowable benefit. Benefits may be reduced as follows: If the total benefits to which a Member

would be entitled under this Certificate and all other Plans, in the absence of this provision, for allowable benefits in one year period, exceed the Member's allowable benefits during same period, then the benefits under this Certificate shall be reduced, when required by the following paragraphs, so that the total benefits under all Plans will not so exceed the allowable benefits for the period. Benefits payable under any other Plan include the benefits that would be payable had the claim been duly made. If any other Plan contains provisions establishing the same rules as are set forth regarding Coordination of Benefits, then the benefits under this Certificate and such other Plan shall be determined by applying the following rules:

C. For the purpose of this Section, the Rules establishing the order of benefits determination are:

1. A Plan with no provision for coordination with other benefits is considered to pay its benefits before a Plan which contains such a provision.

2. Non-Dependent/Dependent. The benefits of the Plan which covers the person as an employee, Member, or Subscriber (that is, other than as a Dependent) are determined before those of the Plan which covers the person as a Dependent.

3. Dependent Child/Parent not separated or divorced. Except as stated in Section 4 below, when this Plan and another Plan cover the same child as a Dependent of different persons, called "parents":

a) The benefits of the Plan of the parent whose birthday falls earlier in a year are determined before those of the Plan of the parent whose birthday falls later in the year; but

b) If both parents have the same birthday, the benefits of the Plan which covered one parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

However, if the other Plan does not have the rule described in (a) immediately above, but instead has a rule based upon the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan will determine the order of benefits.

4. Dependent Child/Separated or Divorced. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

a) First the Plan of the parent with custody of the child;

b) Then the Plan of the spouse of the parent with custody of the child; and

c) Finally, the Plan of the parent not having custody of the child.

However, if the specific terms of a court decree state that one of the parents is responsible for

health care expense of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. The Plan of the other parent shall be the Secondary Plan. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has the actual knowledge.

5. Active/Inactive Employee. The benefits of a Plan which covers a person as an employee who is neither laid off nor retired (or as that employee's Dependent) are determined before those of a Plan which covers that person as a laid off or retired employee (or as that employee's Dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this Rule (5) is ignored.

6. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the benefits of the Plan which covered an employee, Member, or Subscriber longer are determined before those of the Plan which covered that person for the shorter term.

Benefits under this Certificate will not be increased by virtue of this Coordination of Benefits limitation. It shall be the obligation of any Member claiming benefits under this Certificate to notify CarleCare of the existence of all other Group contracts, as well as the benefits payable under any other Group contract. In administering these provisions, CarleCare

shall have the right to release to any Physician, other medical professional, insurance company or any other person or organization, any claim information including copies of records relating thereto, to pay to any other organization any amount determined to be warranted under this Certificate, and to recover any over-payment which CarleCare may have made to any person or organization.

7.4 **If Hospitalized on Effective Date**

A Member who is hospitalized prior to the effective date of his/her enrollment in CarleCare is covered as of the date of eligibility. However, expenses incurred prior to the effective date of eligibility in CarleCare are not covered.

7.5 **Worker's Compensation and Employer Liability Laws**

Care will be provided to CarleCare Members for services covered under Worker's Compensation and employer liability laws. CarleCare will, however, seek reimbursement from the liable third party to the extent of medical liability, and it shall be the duty of the Member to complete such forms and provide such information as may be necessary and proper to assist CarleCare in obtaining reimbursement.

7.6 **Reimbursement for Third Party Liability**

If a member is injured or dies by reason of an act or omission of a third party, other than in relation to Worker's Compensation and employer liability laws covered under Paragraph 7.5 of this Certificate, services and supplies provided pursuant to this Certificate will be furnished to the Member for such injuries. By enrolling, a Member agrees that, if the Member is injured or dies by reason of an act or omission of a third party, CarleCare will have the following rights:

A. A lien in favor of CarleCare on any proceeds received, by way of judgment, settlement, or otherwise, by the Member to the extent of the reasonable cash value of the services and supplies furnished for such injuries. CarleCare may give notice of the lien to the third party whose act or omission caused the injuries to the Member, or his agent or insurance carrier, or where applicable, file the lien in the court having jurisdiction in the matter. A Member will not take any action to prejudice this lien right; and

B. To be reimbursed out of any proceeds received from the third party, to the extent of the reasonable cash value of the services and supplies furnished on behalf of the Member pursuant to this Certificate for such injuries, immediately upon receipt of the proceeds with respect to such Member, whether by judgment, settlement or otherwise. In the event a Member or his personal representative fails to institute a proceeding against such third party at any time prior to six (6) months before such action would be barred, CarleCare may, in its own name or in the name of the Member or his personal representative, commence a lawsuit against such third party for the recovery of damages by reason of such injury or death to the Member. From any damages recovered, CarleCare shall pay to the injured Member or his personal representative all sums received from such third party, whether by judgment, settlement or otherwise, in excess of the amount of the reasonable cash value of the services and supplies furnished pursuant to this Certificate, plus costs, and reasonable attorney's fees and expenses as may be incurred by CarleCare in prosecuting such action. The Member shall not take any action which would prejudice the rights of CarleCare hereunder and will

cooperate in doing what is reasonably necessary to preserve such rights of CarleCare. CarleCare shall not be obligated under the provisions of the fund doctrine for the payment of attorney fees and/or expenses from any proceeds, from whatever source, under which it is entitled to reimbursement hereunder.

Section 8. EXCLUSIONS

The following are NOT covered by CarleCare:

8.1 **Care by Physicians Not Associated with CarleCare**

Care by Physicians, other than CarleCare Physicians or Providers, or in hospitals not associated with CarleCare (except in a medical emergency or as stated in Section 7.2).

8.2 **Governmental Responsibility**

Care for military service connected disabilities for which the Member is legally entitled to services and for which facilities are reasonably available to the Member or for conditions that State or local laws require be treated in a public facility, unless legal liability exists (see Emergency Medical Care, Section 6.19). NOTE: Language taken from Section 110.102(d)(6) of the Federal Register.

8.3 **Services Which Are Not Medically Necessary**

Physical examinations for obtaining or continuing employment, for governmental licensing or for securing insurance coverage, or other services or supplies which are not, in the judgment of CarleCare Physicians, Medically

Necessary for the medical treatment or for the maintenance or improvement of the health of the Member.

8.4 **Cosmetic Surgery**

Conditions for which surgery is indicated primarily for cosmetic purposes (such as skin tags, lipomas). Restorative plastic surgery, however is covered as provided in Section 6.15.

8.5 **Corrective Appliances or Devices, Except as Provided Under 6.22:**

Including hearing aids, earmolds and durable medical equipment not considered Medically Necessary. This includes any dispensing fees incurred in obtaining the above-mentioned items.

8.6 **Orthopedic Devices, Except as Provided Under 6.22:**

Including heel cups, arch supports, gloves, lifts and wedges.

8.7 **Custodial or Convalescent Care**

Custodial or convalescent care for which facilities of an acute general hospital are not Medically Necessary in the judgment of a CarleCare Physician.

8.8 **Dentistry**

Dental care, dentures, restoration, orthodontic splints, correction of malocclusion, repair or extraction of teeth whether erupted or impacted, dental X-rays, anesthesia, analgesia or other professional or hospital charges for services or supplies in connection with treatment of or operations on the teeth or immediately supporting structures, except as expressly provided for in Section 6.11 of this Certificate.

8.9 **Personal, Convenience, Disposable or Comfort Items or Services**

Including grab bars, tub transfers, seat lifts, raised toilet seats, telephone and televisions. Disposable items such as lancets, monojectors and chemstrips are also not covered.

8.10 **Experimental Treatment / Procedures / Transplants**

Regardless of anything stated in this Certificate, CarleCare will not pay benefits for any charges incurred for any treatment, procedure or implant that is deemed to be experimental or investigational in nature by the technological assessment body established by the State of Illinois. Services or supplies related to sex transformation are also not covered.

8.11 **Drugs**

Except as provided by any rider attached hereto, any prescription drugs for outpatient care.

8.12 **Reversal of Sterilization**

Surgical procedures to reverse voluntary sterilization.

8.13 **Elective Abortions**

Abortions which are not Medically Necessary for the life or physical health of the mother are not covered or provided under this Certificate.

8.14 **Infertility Services**

Infertility Services excluded are artificial insemination which is not Medically Necessary, surrogate maternity care when surrogate is not a Member of CarleCare, invitro fertilization, embryo transplants, and other procedures deemed to be experimental or investigational in nature by the

technological assessment body established by the State of Illinois.

8.15 **Refractory Treatment and Hearing Aid Evaluations**

Eyeglasses, contact lenses, contact lens evaluations and fittings, and surgical correction for refractory errors and hearing aid evaluations are not provided.

8.16 **Blood**

Whole blood and its components, including derivatives. Cost relating to the administration and processing of blood and its components are covered.

8.17 Surgical treatment for obesity, such as stapling or by-pass.

8.18 Organ donor treatment or services where the Member serves as the organ donor.

Section 9. GENERAL PROVISIONS

9.1 CarleCare does not itself undertake to directly provide any health service benefits. CarleCare contracts with professional providers of care for the services received by Members under subscription certificates. CarleCare's obligation is limited to furnishing health services through contracts with such providers of care. CarleCare shall not be liable, in any event, for any act or omission of the professional personnel of any medical group, hospital or other provider of services to Members.

9.2 The health services benefits provided for in this Certificate are not transferrable to another party by any Member.

9.3 CarleCare is permitted to charge a reasonable fee to cover its costs for completing medical abstracts or insurance claim forms.

9.4 **Medicare**

A Member who attains the age of 65 or who is otherwise eligible for Medicare (i.e., a recipient of social security disability for a minimum of two years) may qualify for continued eligibility. After Medicare benefits become effective, a CarleCare Member can continue to receive care through the CarleCare facilities and arrangements; however, the Member must assign to the persons or organizations actually providing services or supplies the right to collect the applicable Medicare benefits.

9.5 **Conversion**

In the event that a CarleCare Member becomes ineligible for continued Group membership because of any reasons other than discontinuance of the Group's agreement with CarleCare where there is a succeeding carrier or failure of the employer to pay a required contribution, or because of termination described in Sections 4.5 and 4.6, the Member is eligible to convert to the direct payment plan then being offered by CarleCare for conversion purposes. Conversion must take place within 31 days following the termination of Group eligibility. Benefits and premium rates under the Group and direct payment plans may differ.

9.6 Indemnity in the form of cash will not be paid to any CarleCare Member except as follows:

As reimbursement for payments made to a Physician for which the Member had received prior authorization from CarleCare's Medical Director and for which CarleCare was liable at the time of the services.

As reimbursement for emergency services provided in accordance with Section 6.19.

9.7 The provisions of this Certificate cannot be altered or changed by any representative or agent of CarleCare, other than by a written amendment rider, amendment to the Face Sheet, or endorsement signed by President or Vice President of CarleCare.

9.8 **Medically Necessary - Dispute Resolution**

In the event of a dispute between the Primary Care Physician and CarleCare regarding the medical necessity of a covered service proposed by the Primary Care Physician, CarleCare will coordinate a timely review by a Physician holding the same class of license as the Primary Care Physician. This Physician will be unaffiliated with CarleCare and will be jointly selected by the Member (or the Member's next of kin or legal representative if the Member is unable to act for himself), the Primary Care Physician and CarleCare. If the reviewing Physician determines the covered service to be Medically Necessary, CarleCare will provide coverage for this service.

9.9 By the Group Enrollment Agreement, Group makes CarleCare coverage available to persons who are eligible under Section 2 of this Certificate. However, the Group Enrollment Agreement shall be subject to amendment, modification, or termination in accordance with any provision hereof or by mutual agreement between CarleCare and Group without the consent or concurrence of the Members. By electing medical or hospital coverage pursuant to this Group

Enrollment Agreement or accepting benefits hereunder, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all terms, conditions and provisions hereof.

9.10 **Identification Card**

Cards issued by CarleCare to Members pursuant to this Certificate are for identification only. Possession of a CarleCare identification card confers no right to services or other benefits under this Certificate. To be entitled to such services or benefits, the holder of the card must, in fact, be a Member on whose behalf all applicable premiums under this Certificate have actually been paid. Any person receiving services or other benefits to which he is not entitled pursuant to the provisions of this Certificate shall be charged the Usual and Customary Fee therefore, in addition to any other remedies available to CarleCare as set forth herein. Identification cards are the property of CarleCare and shall be surrendered by Subscriber when CarleCare membership ceases.

9.11 **Clerical Error**

Clerical error, whether of the Group or CarleCare, in processing or maintaining any record pertaining to the coverage under this Certificate, will not invalidate coverage otherwise validly in force or continue coverage otherwise validly terminated.

9.12 **Claims for Reimbursement**

Any claims for reimbursement or bills of non-CarleCare providers for covered medical or hospital services rendered in an emergency must be submitted to CarleCare within sixty (60) days of the provision or initiation of the service, or as soon thereafter as reasonably possible. In no event will CarleCare be responsible for such claims or bills

submitted more than one year after the provisions or initiation of the service to which the claims or bill relates.

9.13 **Grievance Procedure**

Should the Member have a complaint about any medical or administrative matter connected with CarleCare services that is not resolved by the Primary Care Physician, clinic or hospital administrative personnel, the Member may call the CarleCare Member Relations Representative. If the Member feels the problem has not been resolved, the Member may submit a grievance in writing to the CarleCare Patient Satisfaction Committee. Written grievances must be received by the Patient Satisfaction Committee within 180 days from the date the event occurred giving rise to the Member's grievance.

The Patient Satisfaction Committee will meet promptly within thirty (30) days if possible but not longer than forty-five (45) days after receipt of any complaint addressed to the Committee. Each party to the complaint and/or his representative shall be heard by the Patient Satisfaction Committee. The Committee shall deliver and issue a final decision to the Member within ten (10) days of the hearing. The decision, if not contrary to law, contracts in force, or expressed Board policy, will be binding upon CarleCare.

If after review by the Patient Satisfaction Committee the problem is not resolved to the Member's satisfaction, Illinois residents may file a complaint with the Illinois Department of Insurance, Consumer Division or Public Services Section, Springfield, Illinois 62767. Indiana residents may file a complaint with the Department of Insurance, 509 State Office Building, Indianapolis, Indiana 46204.

9.14 Any notice to be given under the terms of this Certificate by CarleCare to the Group shall be in writing and

may be effected by deposit in any post office in the United States addressed to the Group at the most recent address of the Group shown in the records of CarleCare.

Any notice to be given under the terms of this Certificate by CarleCare to a Subscriber shall be in writing and may be effected by deposit in any post office in the United States addressed to the Subscriber at the address shown in the Face Sheet attached to this Certificate, unless notice of change of such address has been given by the Subscriber in the manner provided herein.

Any notice to be given under the terms of this Certificate to CarleCare shall be in writing and may be effected by deposit in any post office in the United States addressed to CarleCare at 602 W. University Avenue, Urbana, Illinois 61801.

All notices given in the manner provided for in this subsection shall be deemed to have been received by the party to whom addressed five (5) business days after deposit in said post office.

ADDITIONAL HUMAN ORGAN TRANSPLANT RIDER
CARLECARE GROUP SUBSCRIPTION
CERTIFICATE

I. Upon prior or written referral of the Member's Primary Care Physician and subject to the terms, conditions, limitations and exclusions of the CarleCare, Inc., Subscription Certificate; the "Human Organ Transplants" Section(s) of the Subscription Certificate are amended by the addition of heart, heart/lung, bone marrow, pancreas, and liver transplants (Additional Transplants) from a donor to a transplant recipient Member when such services occur on or after the Effective Date of this Rider. Benefits under this Rider shall commence no earlier than five (5) days prior to the transplant Surgery and shall continue for a period of no longer than eighteen months after such Surgery. **No organ or tissue not specifically named as covered in the Subscription Certificate or this Rider, shall be eligible for Human Organ Transplants or Additional Transplants.**

II. Whenever a heart, heart/lung, bone marrow, pancreas, or liver transplant (for other than an unmarried dependent child under the limiting age specified in the Subscription Certificate who has biliary artresia) is recommended by or on the referral of the Member's Primary Care Physician, the prospective transplant recipient must contact CarleCare, Inc., prior to the scheduling of the transplant Surgery. CarleCare, Inc., will then furnish the prospective transplant recipient Member or his Primary Care Physician with the names of the Providers which are authorized and approved by CarleCare, Inc., to perform the prescribed and covered transplant. No benefits will be provided for Additional Transplants and/or related services performed by any

Provider other than those which have been pre-approved by CarleCare, Inc.

III. In addition to the other exclusions and limitations of the Subscription Certificate and this Rider, benefits will not be provided for the following:

(A) Services unrelated to the heart, heart/lung, bone marrow, pancreas, or liver transplant except as specified in the Subscription Certificate or unrelated to the diagnosis or treatment of an illness resulting directly from such transplant.

(B) Drugs which are Experimental or Investigational.

IV. Unless earlier terminated by the Terms and Conditions of the CarleCare, Inc., Subscription Certificate, the benefits provided under this Rider shall end upon termination of the Rider by the Equitable Life Assurance Society of the United States.

Except as amended by this Rider, all Terms and Conditions of the CarleCare, Inc., Subscription Certificate to which this Rider is attached, shall remain in full force and effect.